

7349

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Chevy Chase	LENGTH OF STAY (in this place) 9 years	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chevy Chase	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3704 Bradley Lane		STREET ADDRESS (If rural give location) 3704 Bradley Lane	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) HERBERT A. ABBOTT.		4. DATE OF DEATH: (Month) (Day) (Year) July 2 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Oct. 8, 1878
9. AGE last birthday 77 yrs.		IF UNDER 1 YEAR: Months 8 Days 24	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired		10B. KIND OF BUSINESS OR INDUSTRY: ??	11. BIRTHPLACE (State or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Charles F. Abbott	
14. MOTHER'S MAIDEN NAME: Martha W. S. ??		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	
16. SOCIAL SECURITY NO. 231-28-4450		17. INFORMANT & ADDRESS: Ira H. Abbott-Same Item #2	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 2 Uremia			few days.
ANTECEDENT CAUSE (S) (B) Carcinoma of Prostate			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19 2/8 19 to date , 19, that I last saw the deceased alive on 2/7/56 , and that death occurred at 4-11 M. from the causes and on the date stated above.			
SIGNATURE Charles R. E. Hally		DATE SIGNED 4-11 915-19 St. M. W. Wash. D.C.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-transit	DATE THEREOF 7/3/1956	NAME OF CEMETERY OR CREMATORY Pine Hill	LOCATION (City, town, or county) (State) Carroll Co. N. Hampshire
DATE REC'D BY LOCAL REGISTRAR 7-3-56	REGISTRAR'S SIGNATURE Bessie M. Thompson	24. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7350

CERTIFICATE OF DEATH

07290

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
h. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville - R#2</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>				d. STREET ADDRESS <u>Leach Orchard Road - S.S.</u>			
3. NAME OF DECEASED (Type or print) First <u>STEWART</u> Middle <u>G.</u> Last <u>ABELL</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>White MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 26-1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. UNDER 1 YEAR		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor & Builder Building</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Chas Robert Abell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wiley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-01-3894</u>		17. INFORMANT Address <u>Mrs. Lillian L. Abell Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Cardiome Lung Cpr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Lung Cpr</u> DUE TO (c) <u>103no</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 da</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Aug 15, 1956</u> to <u>July 11, 1956</u> that I last saw the deceased alive on <u>July 11, 1956</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N B Steward</u> M.D.				ADDRESS (Street, city or town, state) <u>314 Compton Ave Nixsi</u>			
PHYSICIAN'S NAME (Type) <u>N B Steward</u>				DATE SIGNED <u>July 16 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frances Potter</u>				ADDRESS _____			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. ROY</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>JUL 15 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>CHICAGO, ILL.</i>	
10. OCCUPATION <i>SALES</i>		11. MARITAL STATUS <i>MARRIED</i>		12. PREVIOUS MARRIAGES <i>1</i>	
13. EDUCATION <i>HIGH SCHOOL</i>		14. RELIGION <i>CATHOLIC</i>		15. RACE <i>WHITE</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF WITNESS <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. A.

JUL 16 1956

RECEIVED

7316

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 1/2 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mrs. Laura</u> Middle <u>(none)</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-83</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>James Page</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Record - Sister Mrs. Mary Hopkins</u> Address <u>1319 Noyes Dr. S.S. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO <u>1701</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Metastases from Carcinoma of Breast</u> DUE TO <u>6 months</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 July</u> , 19 <u>56</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.B. Snow</u> M.D. <u>9013 Flower Ave Silver Spring, Md.</u>				DATE SIGNED <u>7/7/56</u>			
PHYSICIAN'S NAME (Type) <u>Lee B. Snow</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>July 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harner & Humphrey 843 Georgia Ave Silver Spring, Md.</u>				24. REC'D BY REGISTRAR <u>J. Wilson Add</u> DATE <u>JUL 10 1956</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 12 1956

RECEIVED

7351

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				d. STREET ADDRESS 4113 Franklin Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) AGUSTA D. ADRIAN		First AGUSTA Middle D. Last ADRIAN		4. DATE OF DEATH Month JULY Day 4 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 19, 1875	
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME CHARLES W. DEY				14. MOTHER'S MAIDEN NAME SAYRE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 1955, to 4 July , 1956, that I last saw the deceased alive on 29 June , 1956, and that death occurred at 7:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert Martyn Jr M.D.				ADDRESS (Street, city or town, state) 5029 Bethesda Ave Bethesda Md			
DATE SIGNED 7/5/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-7-56		22c. NAME OF CEMETERY OR CREMATORY Chestnut Grove		22d. LOCATION (City, town, or county) (State) Herndon, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.K. Hurstmann		ADDRESS 5732 Georgia Ave Washington DC		24a. RECEIVED BY REGISTRAR DATE 7/5/56		24b. REGISTRAR'S SIGNATURE Frances Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text.

Handwritten text in the form:

- NAME: *John Doe*
- DATE: *July 10, 1956*
- CAUSE OF DEATH: *Heart Disease*
- LOCATION: *Home*

RECEIVED
JUL 9 1956
BUREAU Y. 2

7352

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>2 1/2 hrs.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Bertie</u> First <u>Lee</u> Middle <u>Anderson</u> Last			4. DATE OF DEATH <u>July 10</u> Month <u>July</u> Day <u>10</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR: Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Oliver O. Spicer</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter, Anita Walter</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.1 Congestive Heart Failure -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aortic Stenosis and Insufficiency</u> DUE TO (c) <u>Coronary Sclerosis and occlusion -</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>1341.</u> <u>141.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 June</u> , 19 <u>56</u> , to <u>10 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 July</u> , 19 <u>56</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10200 DATE SIGNED</u>					
ACTUAL SIGNATURE <u>John M. Ball</u>		M.D. <u>7936 Georgetown Rd Bethesda Md</u>			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>	<u>July 13, 1956</u>	<u>Congressional</u>	<u>Washington D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>J. William Lewis</u>		<u>Boo-4th & N</u>		<u>7-16-56</u>	<u>Bernice M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1385

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JULY 18, 1956	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
MARRIAGE		OCCUPATION	
M		C	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DETAILS OF CAUSE OF DEATH		DETAILS OF MANNER OF DEATH	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE		DATE	
JULY 18, 1956		JULY 18, 1956	

RECEIVED
JUL 18 1956
BUREAU Y. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seneca Creek and Wightman Rd.		d. STREET ADDRESS R - 1	
3. NAME OF DECEASED (Type or print) Ann Bailey		4. DATE OF DEATH Month July Day 21 Year 1956	
5. SEX female	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1924
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bailey		14. MOTHER'S MAIDEN NAME Eva Coats	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Belle Curtis(aunt) Gaithersburg, R-1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swept in stream by flood waters (in auto)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7/21/56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Seneca Creek		20f. (City or town) (County) (State) Gaithersburg Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/56	
22c. NAME OF CEMETERY OR CREMATORY S. Rose		22d. LOCATION (City, town, or county) (State) Cloppers, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Sworden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR July 25 - 56		24b. REGISTRAR'S SIGNATURE Alfred L. Cooke	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

7354

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			
c. LENGTH OF STAY IN IT <u>4 mo. 1 wk.</u>				d. STREET ADDRESS <u>Brooke Grove Chronic Hosp.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Ferguson</u> Middle <u>Barnsley</u> Last			4. DATE OF DEATH <u>July 13</u> 19 <u>56</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1 1896</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Olney Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D. Barnsley</u>				14. MOTHER'S MAIDEN NAME <u>Caroline E. Torpin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>184-26-2953</u>		17. INFORMANT <u>Deceased</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. Colon + gen. Metastasis</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15, 1956</u> to <u>July 13, 1956</u> that I last saw the deceased alive on <u>July 12, 1956</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Ziegl</u> M.D.				ADDRESS (Street, city or town, state) <u>OLNEY MD</u> DATE SIGNED <u>July 13, 1956</u>			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Olney, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>7-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Esther B. Lowry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. H.

100

RECEIVED

1956 81 70

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 73 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12,412 COLESVILLE ROAD				d. STREET ADDRESS 12,412 COLESVILLE ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS J. Middle BEAN Last BEAN				4. DATE OF DEATH Month JULY Day 30 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/19/82	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (retired)	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MONTGOMERY COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ASBURY B. BEAN				14. MOTHER'S MAIDEN NAME MARGARET BARNES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. HELEN C. BEAN, 12,412 Colesville Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE FRANK J. BROSCART				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/30/56	
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/1/56		22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 7/31/56	
24b. REGISTRAR'S SIGNATURE Francis P. Baker							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67297
Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seneca Creek & Wightman Rd.		d. STREET ADDRESS R - 1	
3. NAME OF DECEASED (Type or print) Leonard Eugene Beckwith		4. DATE OF DEATH Month July Day 21 Year 1956	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 6, 1934
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Md	
11. BIRTHPLACE (State or foreign country) usa		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Robert Beckwith		14. MOTHER'S MAIDEN NAME May Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-30-0314	
17. INFORMANT Mary Beckwith (mother)		Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by drowning 934.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH sudden </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swept in stream by flood water (in auto)	
20c. TIME OF INJURY Month, Day, Year Hour 12:01 a. m. 7/21/56 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Seneca Creek		20f. (City or town) (County) (State) Gaithersburg Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/22/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24	
22c. NAME OF CEMETERY OR CREMATORY Rocky Hill		22d. LOCATION (City, town, or county) (State) Clarkburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray W. Barker</i>		ADDRESS Loylonsville Ind.	
24a. REC'D BY REGISTRAR DATE July 25-56		24b. REGISTRAR'S SIGNATURE <i>Abner L. Cooke</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU K. S.

JUL 30 1956

RECEIVED
JUL 30 1954

Item 3, Film G200, 8/2/56 bh CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery 7357 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Kentucky b. COUNTY Ashland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Goebel Last BELLAMY				4. DATE OF DEATH Month July Day 31 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 April 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.		IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George BELLAMY				14. MOTHER'S MAIDEN NAME Maude PREATOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I & II				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Marguerite U. Bellamy (Same As #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, Myocardial, Acute 420.1 DUE TO posterior Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis, coronary arteries DUE TO (c) 12 hrs. ? years				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma, metastatic, lungs				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Ashland				20g. (County) Kentucky		20h. (State) Kentucky	
21. I certify that I attended the deceased from 26 June , 1956 , to 31 July , 1956 , that I last saw the deceased alive on 31 July , 1956 , and that death occurred at 02:15A , from the causes and on the date stated above.							
ACTUAL SIGNATURE WMB Ingram				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 7/31/56							
PHYSICIAN'S NAME (Type) William B. Ingram, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6 Aug. 1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Ashland Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY Funeral Home, 3557 Wisconsin Ave.,				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-31-56	
				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of hospital		17. Signature of nursing home		18. Signature of other institution	
19. Signature of other institution		20. Signature of other institution		21. Signature of other institution	
22. Signature of other institution		23. Signature of other institution		24. Signature of other institution	
25. Signature of other institution		26. Signature of other institution		27. Signature of other institution	
28. Signature of other institution		29. Signature of other institution		30. Signature of other institution	
31. Signature of other institution		32. Signature of other institution		33. Signature of other institution	
34. Signature of other institution		35. Signature of other institution		36. Signature of other institution	
37. Signature of other institution		38. Signature of other institution		39. Signature of other institution	
40. Signature of other institution		41. Signature of other institution		42. Signature of other institution	
43. Signature of other institution		44. Signature of other institution		45. Signature of other institution	
46. Signature of other institution		47. Signature of other institution		48. Signature of other institution	
49. Signature of other institution		50. Signature of other institution		51. Signature of other institution	
52. Signature of other institution		53. Signature of other institution		54. Signature of other institution	
55. Signature of other institution		56. Signature of other institution		57. Signature of other institution	
58. Signature of other institution		59. Signature of other institution		60. Signature of other institution	
61. Signature of other institution		62. Signature of other institution		63. Signature of other institution	
64. Signature of other institution		65. Signature of other institution		66. Signature of other institution	
67. Signature of other institution		68. Signature of other institution		69. Signature of other institution	
70. Signature of other institution		71. Signature of other institution		72. Signature of other institution	
73. Signature of other institution		74. Signature of other institution		75. Signature of other institution	
76. Signature of other institution		77. Signature of other institution		78. Signature of other institution	
79. Signature of other institution		80. Signature of other institution		81. Signature of other institution	
82. Signature of other institution		83. Signature of other institution		84. Signature of other institution	
85. Signature of other institution		86. Signature of other institution		87. Signature of other institution	
88. Signature of other institution		89. Signature of other institution		90. Signature of other institution	
91. Signature of other institution		92. Signature of other institution		93. Signature of other institution	
94. Signature of other institution		95. Signature of other institution		96. Signature of other institution	
97. Signature of other institution		98. Signature of other institution		99. Signature of other institution	
100. Signature of other institution		101. Signature of other institution		102. Signature of other institution	

BUREAU V. 2

AUG 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7355									
Items 7 & 12, Film G200,									
CERTIFICATE OF DEATH									
Reg. Dist. No. 214									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>47X-3</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs, Md.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Washington, D.C.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena Rest Home</u>					d. STREET ADDRESS <u>3200 McKinley St. N. W.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Bennett</u> Last <u>Bennett</u>					4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>19 56</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5, 1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Australia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
13. FATHER'S NAME <u>Not Known</u>					14. MOTHER'S MAIDEN NAME <u>Not Known</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>3200 McKinley St. N.W.</u> <u>Washington, D.C.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis, severe</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 2</u> , 19 <u>55</u> , to <u>July 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>56</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Harry J. Kuhre</u> M.D. <u>2205 Richland St, Silver Spring Md.</u>					ADDRESS (Street, city or town, state) DATE SIGNED				
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home, 2847 Wilson Blvd.</u> <u>Arlington 1, Va.</u>					24a. REC'D BY REGISTRAR DATE <u>7-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Peltier</u>		

1

07299

56
90

2

I

MEDICAL CERTIFICATION

BUREAU V. 5.

JUL 23 1956

RECEIVED

7359

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 2 hr. 25 min.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland			
d. STREET ADDRESS 4303 N. Pershing Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First William Middle Gary Last BENOIT		4. DATE OF DEATH		Month July Day 31 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 July 1956	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months 2 Days 25	IF UNDER 24 HRS. Hours 2 Min. 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Octave W. BENOIT				14. MOTHER'S MAIDEN NAME Martha Marie LANFORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Father, Octave W. Benoit (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - Prematurity 776 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 hr 25 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 July , 1956, to 31 July , 1956, that I last saw the deceased alive on 1:50 31 July , 1956, and that death occurred at 1:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Howard A. Pearson M.D. U.S. Naval Hospital, Bethesda, Md. 8-1-56							
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 Aug 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS Bethesda, Md. R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave				24a. REC'D BY REGISTRAR DATE 8-1-56		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5.

AUG 3 1956

RECEIVED

7360

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 2320 Jamison, St., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nancy Middle Ellen Last BISHOP				4. DATE OF DEATH Month July Day 25 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-20		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Arthur Moreland				14. MOTHER'S MAIDEN NAME Loe Reese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT (Husband) Henry H. BISHOP (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Acute 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkin's Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 min 3 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 July , 19 56 , to 25 July , 19 56 , that I last saw the deceased alive on 25 July , 19 56 , and that death occurred at 11:00A , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard P. Arentzen M.D.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Maryland			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Willard P. Arentzen, CDR, MC, USN U.S. Naval Hosp. Bethesda, Md. 7-25-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7-27-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661 Goodhope Rd., Washington, DC				24a. REC'D BY REGISTRAR DATE 7-25-56		24b. REGISTRAR'S SIGNATURE Bary E. Parsell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1911		MASSACHUSETTS	
RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1000 BROADWAY		JULY 27, 1956		10:00 AM		HOSPITAL		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SIGNED BY		TITLE	
Carpenter		High School		Married		Roman Catholic		J. H. HARRIS		Physician	
SIGNED BY		TITLE		DATE		PLACE		CAUSE OF DEATH		MANNER OF DEATH	
J. H. HARRIS		Physician		JULY 27, 1956		HOSPITAL		HEART DISEASE		NATURAL	
SIGNED BY		TITLE		DATE		PLACE		CAUSE OF DEATH		MANNER OF DEATH	
J. H. HARRIS		Physician		JULY 27, 1956		HOSPITAL		HEART DISEASE		NATURAL	

BUREAU V. 2

JUL 27 1956

RECEIVED

7361

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>14hr.15 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>5 Arkendale Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>BRENNAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 July 1956</u>	
9. AGE (In years last birthday) yrs. <u>14</u> Months <u>15</u>		10. AGE (In years last birthday) yrs. <u>14</u> Months <u>15</u>		11. AGE (In years last birthday) yrs. <u>14</u> Months <u>15</u>		12. AGE (In years last birthday) yrs. <u>14</u> Months <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>			
11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Bruce James BRENNAN</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise MOORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>(Mother) Mary Louise BRENNAN (Same As #2)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immaturity (29 wks) Prematurity</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-10-56</u> , 19 <u>56</u> , to <u>7-10-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-10-56</u> , 19 <u>56</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u> DATE SIGNED <u>7-11-56</u>							
ACTUAL SIGNATURE <u>H. A. Pearson</u>				M.D. <u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. A. PEARSON, LT, MC, USN</u>				U.S. Naval Hospital, NNMC, Bethesda, Md. <u>7-11-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.,				24a. REC'D BY REGISTRAR DATE <u>7-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTERED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7362

CERTIFICATE OF DEATH

Reg. Dist. No. 216

07303

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>9 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>101 TULIP DRIVE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM STANLEY BRIGGS</u>				4. DATE OF DEATH Month Day Year <u>JULY 21 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/24</u>		9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSE FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>CHARLES EDWARD BRIGGS</u>				14. MOTHER'S MAIDEN NAME <u>WOLFE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES-ARMY WWII</u>		16. SOCIAL SECURITY NO. <u>216-180617</u>		17. INFORMANT <u>MRS. CAROLYN BRIGGS-GAITHERSBURG MD.</u>		Address <u>101 TULIP DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured cerebral aneurysm</u> DUE TO (c) <u>13 days</u> <u>13 days</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-8</u> , 19 <u>56</u> , to <u>7-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-20</u> , 19 <u>56</u> , and that death occurred at <u>6:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.H. Hall</u>				ADDRESS (Street, city or town, state) <u>615 W. Montgomery Rd. Rockville, Md.</u>		DATE SIGNED <u>7-21-56</u>	
PHYSICIAN'S NAME (Type) <u>W.H. Hall</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 23 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOREST OAK</u>		22d. LOCATION (City, town, or county) (State) <u>GAITHERSBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>				ADDRESS <u>Rockville</u>		24a. REC'D BY REGISTRAR <u>Benjamin Thompson</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 27 1956

RECEIVED

July 23/75 Forest Oak

1880-1881

7363

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1533 No. Kenilworth Street	
3. NAME OF DECEASED (Type or print) First Inez Middle Coffee Last Brogden		4. DATE OF DEATH Month July Day 18 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5, 1915
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk typist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry L. Coffee		14. MOTHER'S MAIDEN NAME Cora Noell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleural Effusion, pulmonary edema, tuberculous 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma involving pleura, lungs, and other organs DUE TO (c) Duct Cell Carcinoma, Right Breast INTERVAL BETWEEN ONSET AND DEATH 1 year 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 20 , 19 56 , to July 18 , 19 56 , that I last saw the deceased alive on July 18 , 19 56 , and that death occurred at 7:25 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Weiger		ADDRESS (Street, city or town, state) DATE SIGNED 7/19/56	
PHYSICIAN'S NAME (Type) Robert Weiger, M. D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 20 19 56	Cedar Hill	Smithland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lee's Sons, Inc.		24a. REC'D BY REGISTRAR DATE - 23 - 56	24b. REGISTRAR'S SIGNATURE Bennie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07305

7364

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 58 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum 16X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 1307 Legation Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vivian Viola Brookbank				4. DATE OF DEATH Month Day Year July 17 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 November 1906	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 8 14		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Representative Telephone Company Vermont		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Clinton H. Woodcock				14. MOTHER'S MAIDEN NAME Margaretha J. Halfpapp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-01-0632		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Mitral insufficiency following Commensal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 May 1956 to 17 July 1956 , that I last saw the deceased alive on 17 July 1956 , and that death occurred at 11:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard J. Sanders M.D.				ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center July 17, 1956			
PHYSICIAN'S NAME (Type) Richard J. Sanders, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-20-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Prince Georges Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR DATE 18-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

BUREAU V. 8

JUL 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7365

CERTIFICATE OF DEATH

07306

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MAUD WILKINS BURDETTE				4. DATE OF DEATH Month Day Year July 14, 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 May 1884	
9. AGE (In years last birthday) 72 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin N. S. Wilkins		14. MOTHER'S MAIDEN NAME Rebecca Rodgers Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address W. L. Burdette, Hyattstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder with generalized metastases 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from January 8, 1956 to July 14, 1956 , that I last saw the deceased alive on July 12, 1956 , and that death occurred at 5:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Maryland DATE SIGNED 16 July 1956							
ACTUAL SIGNATURE James P. Kerr M.D.				PHYSICIAN'S NAME (Type) James P. Kerr, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 17 July 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 18 1956		24b. REGISTRAR'S SIGNATURE Della H. Burdette	

7366 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>N.J.</u>		COUNTY <u>Camden</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Cherry Chase</u>		RURAL LENGTH OF STAY (in this place) <u>10 mos.</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Gloucester</u>		<u>67X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4609 Willard Ave. Cherry Chase 15, Md.</u>				STREET ADDRESS (If rural give location) <u>815 Monmouth St.</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Joseph</u> (Last) <u>Burke, JR</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 1 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>OCT. 15, 1876</u>	9. AGE last birthday: <u>79</u> yrs. <u>8</u> months <u>16</u> days	IF UNDER 1 YEAR		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Shipbuilding</u>		11. BIRTHPLACE (State or foreign country): <u>Camden, N.J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>John JOSEPH Burke, Sr</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Moran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>Mrs T. A. Inglesby-4609 Willard Ave.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>450.0</u> <u>Arteriosclerosis generalized</u>				<u>- 5-3 -</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>(with cerebral focalization)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 June, 1956</u> to <u>1 July 1956</u> that I last saw the deceased alive on <u>29 June, 1956</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harry A. Hartman</u>				ADDRESS <u>1835 Eye St NW Wash D.C.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>JULY 5 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Camden N.J.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-2-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>J. Williams & Co.</u>		ADDRESS <u>300 - 4 St N E</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 July 1956 -

Certificate - This is to
certify that I pronounced Mr.
John Joseph Burke dead at 7:05 AM.
1 July '56 at 4609 Willard Ave. Chevy
 Chase 15, Md. Harry A. Hartsman Jr.

RECEIVED

JUL 5 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7367

07308

CERTIFICATE OF DEATH

Item 13: Film G200 7/24/56

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>12 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5734-13th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Ann Burke</u>		4. DATE OF DEATH <u>July 11</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1881</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Joyce Burke</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Connolly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daughter, Julia B. Clifford</u>		Address <u>1209 Exeter Rd., Bethesda</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>56</u> , to <u>7/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/11/56</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. T. Joyce</u>		DATE SIGNED <u>7/11/56</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		ADDRESS (Street, city or town, state) <u>8106 Maple Ridge Rd., Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-14-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Humphreys & Son</u>		ADDRESS <u>5732 Ma Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE 7-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>1910</i>		PLACE OF BIRTH <i>New York</i>		CITY OF BIRTH <i>New York</i>		STATE OF BIRTH <i>New York</i>		COUNTRY OF BIRTH <i>United States</i>		DATE OF DEATH <i>1956</i>		PLACE OF DEATH <i>New York</i>		CITY OF DEATH <i>New York</i>		STATE OF DEATH <i>New York</i>		COUNTRY OF DEATH <i>United States</i>					
MARRIED <i>Yes</i>		WIDOWED <i>No</i>		DIVORCED <i>No</i>		SEPARATED <i>No</i>		SINGLE <i>No</i>		MARRIED <i>Yes</i>		WIDOWED <i>No</i>		DIVORCED <i>No</i>		SEPARATED <i>No</i>		SINGLE <i>No</i>		MARRIED <i>Yes</i>		WIDOWED <i>No</i>		DIVORCED <i>No</i>		SEPARATED <i>No</i>		SINGLE <i>No</i>			
EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		INDUSTRY <i>Education</i>		TRADE <i>None</i>		PROFESSION <i>None</i>		MILITARY SERVICE <i>No</i>		NAVY SERVICE <i>No</i>		AIR FORCE SERVICE <i>No</i>		ARMY SERVICE <i>No</i>		MARINE SERVICE <i>No</i>		COAST GUARD SERVICE <i>No</i>		OTHER SERVICE <i>No</i>		MILITARY SERVICE <i>No</i>		NAVY SERVICE <i>No</i>		AIR FORCE SERVICE <i>No</i>		ARMY SERVICE <i>No</i>	
RELIGION <i>Protestant</i>		POLITICAL PARTY <i>Democrat</i>		SOCIAL PARTY <i>None</i>		ETHNICITY <i>White</i>		LANGUAGE <i>English</i>		NATURALIZATION <i>Yes</i>		CITIZENSHIP <i>Yes</i>		RESIDENCE <i>New York</i>		DURATION OF RESIDENCE <i>10 years</i>		PREVIOUS RESIDENCE <i>None</i>		PREVIOUS RESIDENCE <i>None</i>		PREVIOUS RESIDENCE <i>None</i>		PREVIOUS RESIDENCE <i>None</i>		PREVIOUS RESIDENCE <i>None</i>		PREVIOUS RESIDENCE <i>None</i>		PREVIOUS RESIDENCE <i>None</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>		UNDERLYING CAUSE <i>Arteriosclerosis</i>		PREEXISTING DISEASES <i>Hypertension</i>		ACUTE DISEASES <i>None</i>		CHRONIC DISEASES <i>None</i>		TRAUMA <i>None</i>		POISONING <i>None</i>		INFECTIOUS DISEASES <i>None</i>		PARASITIC DISEASES <i>None</i>		NEOPLASMS <i>None</i>		OTHER DISEASES <i>None</i>		OTHER DISEASES <i>None</i>		OTHER DISEASES <i>None</i>	
DATE OF EXAMINATION <i>1956</i>		PLACE OF EXAMINATION <i>New York</i>		CITY OF EXAMINATION <i>New York</i>		STATE OF EXAMINATION <i>New York</i>		COUNTRY OF EXAMINATION <i>United States</i>		DATE OF EXAMINATION <i>1956</i>		PLACE OF EXAMINATION <i>New York</i>		CITY OF EXAMINATION <i>New York</i>		STATE OF EXAMINATION <i>New York</i>		COUNTRY OF EXAMINATION <i>United States</i>		DATE OF EXAMINATION <i>1956</i>		PLACE OF EXAMINATION <i>New York</i>		CITY OF EXAMINATION <i>New York</i>		STATE OF EXAMINATION <i>New York</i>		COUNTRY OF EXAMINATION <i>United States</i>			

RECEIVED
JUL 16 1956
BUREAU V. S.

7368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Gaithersburg</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D./# 3 Gaithersburg</u>				d. STREET ADDRESS <u>Rural-Gaithersburg</u>			
3. NAME OF DECEASED (Type or print) <u>JAMES M. BURNLEY</u>				4. DATE OF DEATH <u>INDEX July 1, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-96</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wm. Mason Burnley</u>				14. MOTHER'S MAIDEN NAME <u>Marion M. Holtzman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>		17. INFORMANT <u>Eugenia A. Burnley-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>DIABETES MELLITUS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>ON 2 HOUR</u> <u>10 YRS</u> <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov-3, 1956</u> , to <u>JUNE 28 1956</u> , that I last saw the deceased alive on <u>JUNE 28, 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u>		DATE SIGNED <u>July 1, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger-Rockville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>7/3/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Laurell Kraglar</u>			

CERTIFICATE OF DEATH

1956

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 2

JUL 5 1956

RECEIVED

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

67310

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN TAKOMA PARK		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON SAN. & HOSPITAL				STREET ADDRESS 12,914 FLACK STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ADDIE (Middle) ELLEN (Last) CANDISH				(Month) JULY (Day) 27 (Year) 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 4, 1867	9. AGE last birthday 89 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Bradford, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Caywood				14. MOTHER'S MAIDEN NAME Mary E. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mr. Paul C. Candish, 12,914 Flack St. Silver Spring, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170X IMMEDIATE CAUSE (A) Carcinoma Breast				INTERVAL BETWEEN ONSET AND DEATH 3-4 years			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 15, 1956, to July 27, 1956, that I last saw the deceased alive on July 27, 1956, and that death occurred at 3:45 P.M. from the causes and on the date stated above.							
SIGNATURE W.B. Candish M.D.				DATE SIGNED 7/27/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		DATE THEREOF 8/1/56		NAME OF CEMETERY OR CREMATORY GRAND ISLAND CEMETERY		LOCATION (City, town, or county) (State) GRAND ISLAND, NEBRASKA	
24. REC'D BY REGISTRAR JUL 31 1956		REGISTRAR'S SIGNATURE J. Wilson Dodd		25. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Humphrey		ADDRESS SILVER SPRING, MD.	

CERTIFICATE OF DEATH

Reg. Dist. No.

MUST BE FILLED IN BY PHYSICIAN OR REGISTRAR

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES A. HARRIS		MALE		45		JAN 15 1880		BOSTON		MASSACHUSETTS		UNITED STATES			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
FARMER		HEART DISEASE		NATURAL		2 WEEKS		JAN 25 1936		BOSTON		MASSACHUSETTS		UNITED STATES	
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE	
HIGH SCHOOL		METHODIST		MARRIED		1905		BOSTON		MASSACHUSETTS		UNITED STATES			
SCHOOLING		BORN		DIED		DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		CITY		STATE	
10 YEARS		JAN 15 1880		JAN 25 1936		BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES			
FATHER'S NAME		MOTHER'S NAME		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
JAMES HARRIS		MARY HARRIS		JAN 25 1936		BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES			
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
FARMER		HOUSEWIFE		JAN 25 1936		BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES			
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
JAN 15 1850		JAN 15 1850		JAN 25 1936		BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES			
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
BOSTON		BOSTON		JAN 25 1936		BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES			
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
FARMER		HOUSEWIFE		JAN 25 1936		BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES			

BUREAU V. 3

JUG 1 1956

RECEIVED

EXHIBIT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07311

7318

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Rest Home				d. STREET ADDRESS 8213 Maple Ridge Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM J. CANDY				4. DATE OF DEATH July 14, 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1865	
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months 10 Days 19		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. -Merchant				10b. KIND OF BUSINESS OR INDUSTRY Owner-Hardware		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Minnie D. Candy-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, cerebral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Senility				INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia, left				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-22- 1952 , to 7-14- 1956 , that I last saw the deceased alive on 7-13- 1956 , and that death occurred at 12:30 A. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel A. Hillman				ADDRESS (Street, city or town, state) 249 Missouri Ave. N.W.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Samuel A. Hillman				249 Missouri Ave., N.W. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 4-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased Mon. Lomery		Sex Male	
Place of Birth Baltimore, Md.		Age 25	
Residence 213 Maple Ridge Road		Date of Death July 1, 1956	

Cause of Death Heart - Atherosclerosis		Place of Death Home	
Manner of Death Natural		Date of Report July 1, 1956	
Signature of Physician J. L. Lomery		Signature of Registrar J. L. Lomery	

Signature of Deceased Mon. Lomery		Signature of Next of Kin Mrs. Lomery	
Signature of Witness J. L. Lomery		Signature of Witness J. L. Lomery	
Signature of Witness J. L. Lomery		Signature of Witness J. L. Lomery	

BUREAU V. M.		JUL 13 1956	
RECEIVED		JUL 13 1956	

7369

CERTIFICATE OF DEATH

07312

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>AFD #4 Edson Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hubert John Casey</u>				4. DATE OF DEATH Month Day Year <u>7-16-1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-24-81</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>1 22</u>		IF UNDER 24 HRS. Hours Min. <u>1 22</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>London, England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>England</u>							
13. FATHER'S NAME <u>John J. Casey</u>				14. MOTHER'S MAIDEN NAME <u>Emily Musgrove</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-32-1638</u>		17. INFORMANT <u>Geraldine M. Casey - wife</u> Address <u>AFD #4 Edson Lane Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Atherosclerotic Artery</u> DUE TO <u>Generalized Atherosclerosis</u> DUE TO <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>430.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 29, 1957</u> , to <u>July 16, 1956</u> , that I last saw the deceased alive on <u>July 16, 1956</u> , and that death occurred at <u>6:18 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9600 Old Georgetown Rd. Bethesda, Md.</u> DATE SIGNED <u>7/17/56</u> ACTUAL SIGNATURE <u>Joseph D. Connor</u> M.D. <u>9600 Old Georgetown Rd. Beth Md</u> PHYSICIAN'S NAME (Type) <u>Joseph D. Connor</u> <u>9600 Old Georgetown Rd. Beth Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7282

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1905		BALTIMORE		MD		USA			
OCCUPATION		MARITAL STATUS		EDUCATION		RELIGION		RACE		COLOR		HAIR		EYES	
LABORER		MARRIED		HIGH SCHOOL		METHODIST		WHITE		WHITE		BROWN		BLUE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POSTMORTEM	
JUL 20 1956		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 1

JUL 20 1956

RECEIVED

7370

CERTIFICATE OF DEATH

07313

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 15X-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNM		d. STREET ADDRESS 4521 Sangamore Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH July 21 1956	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1956	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR: Months 6 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Michel N. CAVALUZZI		14. MOTHER'S MAIDEN NAME Rosemary H. CAVALUZZI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Birth Injury 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs. 5 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 July 1956 , to 21 July 1956 , that I last saw the deceased alive on 21 July 1956 , and that death occurred at 10:25 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) USNH, NNM, Bethesda, Maryland	
ACTUAL SIGNATURE George J. G. Magnant M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) G. J. A. MAGNANT LT MC USNR		USNH, NNM, Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-24-56	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet, Blandsburg Road, N.E., Washington, D. C.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE DeVolpe Funeral Home 2224 Wisconsin Ave., N.W., Washington, D. C.		24a. REC'D BY REGISTRAR 7-21-56	
		24b. REGISTRAR'S SIGNATURE Barry E. Parrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

• • •

110

1998

10

1990

5.1, notg. 1951?

JUL 24 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

7371

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lelia Middle ARLITA Last Chapman				4. DATE OF DEATH Month July Day 22 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1895	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESS BUYER			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME JAMES H. MOORE				14. MOTHER'S MAIDEN NAME BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNK.		17. INFORMANT MR. JOHN L. CHAPMAN, JR. Address 10120 GARY RD. ROCKVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pylonephritis DUE TO (c) Chronic Acetophenetidin injection							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May 15, 1956 , to July 22, 1956 , that I last saw the deceased alive on July 12, 1956 , and that death occurred at 4:48 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred S. Norton				ADDRESS (Street, city or town, state) 4711 Highland Ave., Bethesda, Md.			
PHYSICIAN'S NAME (Type) Alfred S. Norton				DATE SIGNED July 22, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/25/56	22c. NAME OF CEMETERY OR CREMATORY Resthaven Cemetery	22d. LOCATION (City, town, or county) (State) Oakley, OHIO				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Maryland			24a. REC'D BY REGISTRAR DATE 7-24-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **07315**

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY NONE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 68 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EMMA JANE CLAMPITT		4. DATE OF DEATH Month Day Year JULY 29 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/77
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT	
11. BIRTHPLACE (State or foreign country) WASH., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME NEHEMIAH ROBEY		14. MOTHER'S MAIDEN NAME Octavia Moreland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT VERA CLAMPITT RICE-CHENEYCHASE		Address 2818 SPENCER RD. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis DUE TO 298.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancreatic apoplexy (c) Splenic Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 72 hrs ? years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peripheral Vascular Collapse			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 July, 1956 to 29 July, 1956 , that I last saw the deceased alive on 28 July, 1956 , and that death occurred at 8:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward C. Wilson, Jr. M.D.		ADDRESS (Street, city or town, state) 1801 Eye St. N.W. DATE SIGNED	
PHYSICIAN'S NAME (Type) Edward C. Wilson, Jr. M.D. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/56	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE St. John's Co., Washington D.C.		ADDRESS St. John's Co., Washington D.C.	
24a. REC'D BY REGISTRAR DATE 31-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
SEX FEMALE		RACE WHITE	
DATE OF DEATH AUG 3 1956		TIME OF DEATH 10:00 AM	
AGE 72		MARRIAGE MARRIED	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
SEX FEMALE		RACE WHITE	
DATE OF DEATH AUG 3 1956		TIME OF DEATH 10:00 AM	
AGE 72		MARRIAGE MARRIED	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	

CAUTION

BUREAU V. R.

AUG 3 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07316** *216*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>3 wks</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4312 Willow Lane</i>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4511 Gladwyn Dr</i> d. STREET ADDRESS <i>Bethesda Md</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Celine Neary</i> First <i>Neary</i> Middle <i>XXXXXXXXXX</i> Last <i>Coffey</i>				4. DATE OF DEATH Month <i>July</i> Day <i>20</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-12-1884</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>							
13. FATHER'S NAME <i>Pat Neary</i>				14. MOTHER'S MAIDEN NAME <i>Nancy Pea</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Thos. Coffey (husband)</i> Address <i>Same as Decd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>sudden</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. BROSCHART</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/31/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		22d. LOCATION (City, town, or county) (State) <i>Aspen Hills, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i> ADDRESS				24a. REC'D BY REGISTRAR <i>F-2-56</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 5 1956
BUREAU V. S.

7319

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp</u>				d. STREET ADDRESS <u>8101 14th Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Janet</u> First Middle Last <u>Costelloe</u>				4. DATE OF DEATH <u>July</u> Month <u>8</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H SWF</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Sanger</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Lauterbach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X Congestive Heart failure</u> DUE TO (b) <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks since childhood</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1, 1956</u> to <u>July 8, 1956</u> , that I last saw the deceased alive on <u>July 8, 1956</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rablain</u>				ADDRESS (Street, city or town, state) <u>8102 University Lane, Silver Spring, Md</u> DATE SIGNED <u>July 8, 1956</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-10-56</u>		<u>Maple Grove Cemetery</u>		<u>Long Island, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th St NW Wash, DC</u>				24a. REC'D BY REGISTRAR <u>DATE 10 1956</u> 24b. REGISTRAR'S SIGNATURE <u>J. Nelson Duddy</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
JAMES J. JONES		Male		45		1880		New York		Clerk		Heart Disease		Natural		J. J. Jones		J. J. Jones	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. SEX OF DECEASED		15. AGE OF DECEASED		16. DATE OF BIRTH		17. PLACE OF BIRTH		18. OCCUPATION		19. CAUSE OF DEATH		20. MANNER OF DEATH	
New York		1956		10:00 AM		Male		45		1880		New York		Clerk		Heart Disease		Natural	
21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

BUREAU V. 2

JUL 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07318

Reg. Dist. No. 2/6

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
c. LENGTH OF STAY IN 1b <i>1 hour</i>		d. STREET ADDRESS <i>5002 Dalton Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Baby Girl</i> Middle <i>Crampton</i> Last <i>Crampton</i>		4. DATE OF DEATH Month <i>July</i> Day <i>16</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 16/56</i>
9. AGE (In years last birthday) yrs. <i>7</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Gilbert Lee Crampton</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte White Reed</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mother</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> DUE TO <i>762.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Premature</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 16, 1956</i> , to <i>July 16, 1956</i> , that I last saw the deceased alive on <i>July 16, 1956</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>74650</i> DATE SIGNED <i>md.</i>			
ACTUAL SIGNATURE <i>A.B. Irwin, Jr.</i>		M.D. <i>Rockville Medical Center, Rockville</i>	
PHYSICIAN'S NAME (Type) <i>A.B. Irwin, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>July 23, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Adlington National</i>		22d. LOCATION (City, town, or county) (State) <i>Adlington 92</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ever Funeral Home</i> ADDRESS <i>237 S.E. Sulphur Adlington 92</i>		24a. REC'D BY REGISTRAR <i>DATE 30 1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. RACE	
7. OCCUPATION		8. MARITAL STATUS	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. PLACE OF DEATH		12. DATE OF DEATH	
13. CAUSE OF DEATH		14. MANNER OF DEATH	
15. PLACE OF DEATH		16. DATE OF DEATH	
17. PLACE OF DEATH		18. DATE OF DEATH	
19. PLACE OF DEATH		20. DATE OF DEATH	
21. PLACE OF DEATH		22. DATE OF DEATH	
23. PLACE OF DEATH		24. DATE OF DEATH	
25. PLACE OF DEATH		26. DATE OF DEATH	
27. PLACE OF DEATH		28. DATE OF DEATH	
29. PLACE OF DEATH		30. DATE OF DEATH	
31. PLACE OF DEATH		32. DATE OF DEATH	
33. PLACE OF DEATH		34. DATE OF DEATH	
35. PLACE OF DEATH		36. DATE OF DEATH	
37. PLACE OF DEATH		38. DATE OF DEATH	
39. PLACE OF DEATH		40. DATE OF DEATH	
41. PLACE OF DEATH		42. DATE OF DEATH	
43. PLACE OF DEATH		44. DATE OF DEATH	
45. PLACE OF DEATH		46. DATE OF DEATH	
47. PLACE OF DEATH		48. DATE OF DEATH	
49. PLACE OF DEATH		50. DATE OF DEATH	
51. PLACE OF DEATH		52. DATE OF DEATH	
53. PLACE OF DEATH		54. DATE OF DEATH	
55. PLACE OF DEATH		56. DATE OF DEATH	
57. PLACE OF DEATH		58. DATE OF DEATH	
59. PLACE OF DEATH		60. DATE OF DEATH	
61. PLACE OF DEATH		62. DATE OF DEATH	
63. PLACE OF DEATH		64. DATE OF DEATH	
65. PLACE OF DEATH		66. DATE OF DEATH	
67. PLACE OF DEATH		68. DATE OF DEATH	
69. PLACE OF DEATH		70. DATE OF DEATH	
71. PLACE OF DEATH		72. DATE OF DEATH	
73. PLACE OF DEATH		74. DATE OF DEATH	
75. PLACE OF DEATH		76. DATE OF DEATH	
77. PLACE OF DEATH		78. DATE OF DEATH	
79. PLACE OF DEATH		80. DATE OF DEATH	
81. PLACE OF DEATH		82. DATE OF DEATH	
83. PLACE OF DEATH		84. DATE OF DEATH	
85. PLACE OF DEATH		86. DATE OF DEATH	
87. PLACE OF DEATH		88. DATE OF DEATH	
89. PLACE OF DEATH		90. DATE OF DEATH	
91. PLACE OF DEATH		92. DATE OF DEATH	
93. PLACE OF DEATH		94. DATE OF DEATH	
95. PLACE OF DEATH		96. DATE OF DEATH	
97. PLACE OF DEATH		98. DATE OF DEATH	
99. PLACE OF DEATH		100. DATE OF DEATH	

BUREAU V. 8

JUL 30 1956

RECEIVED

7320

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven</u>				d. STREET ADDRESS <u>205-Varnum NW</u>			
3. NAME OF DECEASED (Type or print) First <u>Neale</u> Middle <u>P. Crismond</u> Last <u>Neale</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/27/72</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk-Retired Telephone Co.</u>		<u>Telephone Co.</u>		<u>Newport Chas. Co. Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>John J. Crismond</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Neale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-01-2187</u>			
17. INFORMANT <u>Fred Stone Crismond</u>				Address <u>Edgewater, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Hemorrhage</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) <u>General Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>56</u> , to <u>July 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>56</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Spire</u>				DATE SIGNED <u>7/2/56</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD H. SPIRE</u>				ADDRESS (Street, city or town, state) <u>4601 16th St N.W. Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Lane</u>				ADDRESS <u>3200 R. I. Ave. Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>John D. Hall</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>7/12/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

11

Blank form area for the Certificate of Death, containing various fields for personal and medical information.

BUREAU V. 3

JUL 16 1956

RECEIVED

00007 R. J. ...
JUL 16 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> c. LENGTH OF STAY IN 1b <u>Brookville</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> d. STREET ADDRESS <u>RFD</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WINFRED</u> First Middle Last <u>DORSEY</u> <u>CROSBY</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>26</u> , <u>19</u> <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>September 2, 1887</u> 68 yrs.
9. AGE (In years last birthday) <u>10</u> Months <u>24</u> Days <u>56</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Thomas Dorsy</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Hannigan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs R.W. Janney- Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right Hemiplegia</u> (c) <u>Arterio Sclerosis, Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 year</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>L</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/4</u> , 19 <u>55</u> , to <u>7/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/24</u> , 19 <u>56</u> , and that death occurred on <u>7/26</u> , 19 <u>56</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>7/26/56</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>J.W. Bird- Sandy Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-26-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bertrud B Lawler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE IN STATE		COUNTY	
DATE OF DEATH		HOUR OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MANNER OF DEATH	
CAUSE OF DEATH		IMMEDIATE CAUSE	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PREVIOUS ILLNESS		HABITS	
DIET		EXERCISE	
CLIMATE		LOCALITY	
WIND		TEMPERATURE	
MOON		STAR	
PLANET		SIGN	
CONSTELLATION		PHASE	
ECLIPSE		METEOR	
COMET		AURORA	
SOLAR FLARE		COSMIC RAY	
MAGNETIC STORM		VOLCANIC ERECTION	
EARTHQUAKE		Tsunami	
FLOOD		DROUGHT	
HAIL		ICE STORM	
THUNDER		LIGHTNING	
WINDSTORM		TYPHOON	
TORNADO		HURRICANE	
FIRE		EXPLOSION	
POISONING		SUICIDE	
MURDER		ACCIDENT	
OTHER		UNSPECIFIED	

BUREAU V. S.

JUL 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67321

7376

CERTIFICATE OF DEATH

Items 7,8,9,17: film G200

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1103 Manor Road	
3. NAME OF DECEASED (Type or print) First Richard Middle Oscar Last Crump		4. DATE OF DEATH Month July Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1914
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK Clerk		10b. KIND OF BUSINESS OR INDUSTRY DryGoods	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Crump		14. MOTHER'S MAIDEN NAME Malissa Kersey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 223-10-2834	
17. INFORMANT The Medical Record		Address: Also: GAYLE CRUMP, 3202 Kendall I. av. Richmond, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA AND PULMONARY INFARCTS 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) GANGRENE OF LEGS FROM ARTERIAL OCCLUSION DUE TO (c) METASTATIC CHONDROSARCOMA TO LIVER, LUNGS INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS 2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 56 , to July 2 , 19 56 , that I last saw the deceased alive on July 2 , 19 56 , and that death occurred at 8:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Horace Herbsman		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) Horace Herbsman, M. D.		DATE SIGNED 7/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 3, 1956	
22c. NAME OF CEMETERY OR CREMATORY Richmond, VA		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Taltavull		ADDRESS 3619-14 4th Ave	
24a. REC'D BY REGISTRAR DATE 7-5-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
The Clinton I. Jones, Jr.		Male		35	
Date of Death		Place of Death		Cause of Death	
July 1, 1956		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:30 AM		Natural		Physician	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

1956 JUL 9

BUREAU V. 3

RECEIVED

3-15-56

11:44 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be notified. The funeral director should be notified by the funeral director. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7377

CERTIFICATE OF DEATH

07322

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <i>Montgomery Co. MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sumerset</i>		c. LENGTH OF STAY IN 1b <i>Sumerset</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4719 Dorset Ave.</i>		d. STREET ADDRESS <i>4719 Dorset Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>WILLIAM R. H. CRUMP</i>		4. DATE OF DEATH <i>July 22, 1956</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 17, 1863</i>	
9. AGE (In years last birthday) <i>92</i>		IF UNDER 1 YEAR <i>9</i> Months <i>3</i> Days <i>5</i> Hours <i>Min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wholesaler</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Lawrence Crump</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Hankins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Kathleen Wheeler Crump- Item # 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Heart Failure</i> DUE TO <i>Hypertension & Arteriosclerosis & mal-nutrition</i> (b) <i>mal-nutrition</i> DUE TO <i>(D) - Age - general debility</i> (c) <i>Dehydration - urinary retention - Cataracts</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 2 days</i> <i>not known</i> <i>" "</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb</i> <i>1951</i> , to <i>July 22, 1956</i> that I last saw the deceased alive on <i>July 21, 1956</i> , and that death occurred at <i>12:00 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>2025-Exe St. W. W. DC 7/22/56</i>	
ACTUAL SIGNATURE <i>Jobule Reisinger</i>		PHYSICIAN'S NAME (Type) <i>Jobule Reisinger</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>7/23/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE 7-24-56</i>	
24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JULY 26 1955		BALTIMORE		BALTIMORE		MD		JULY 26 1955		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 2

JUL 26 1955

RECEIVED

7321

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jonathan</u> Middle <u>Francis</u> Last <u>Deane</u>				4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-75</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William H. Deane</u>				14. MOTHER'S MAIDEN NAME <u>Kate Riordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>088-095280</u>			
17. INFORMANT <u>Charles J. Deane</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uraemia</u> 592X DUE TO (b) <u>Chronic Glomerular Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>July 18</u> , 19 <u>55</u> , to <u>July 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>56</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							DATE SIGNED <u>7/8/56</u>
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D. <u>9241 Col. Blvd</u>							
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u> <u>Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>4349A Ave.</u> REC'D BY REGISTRAR <u>10 1558</u> REGISTRAR'S SIGNATURE <u>J. Marion Bankhead</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

REASON FOR DEPARTURE

BUREAU V. S.

JUL 12 1956

RECEIVED

7378

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bethesda, Md.		c. LENGTH OF STAY IN 1b 24 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Naval Hospital, NNMCM, Bethesda		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tillman Middle Trotter Last DANTZLER		4. DATE OF DEATH Month July Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Feb 1904
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Miss.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Brother in Law Address Dan A. HODGES 2356 N. Early St. Alex, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 INFARCTION, MYOCARDIAL, ACUTE DUE TO thrombosis, Rt. + left Ant. Cor. AA. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, CORONARY AA. (4 GEN'ld) (c) ?		INTERVAL BETWEEN ONSET AND DEATH 2 days 2+ days 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 July 19 56 , to 7 July 19 56 , that I last saw the deceased alive on 7 July 19 56 , and that death occurred at 5:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Ingram		ADDRESS (Street, city or town, state) USNH, NNMCM, Bethesda, Maryland DATE SIGNED 7/8/56	
PHYSICIAN'S NAME (Type) W. B. INGRAM, CDR MC USN		USNH, NNMCM, Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11 Jul 1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Boulevard, Arlington, Virginia		24a. REC'D BY REGISTRAR DATE 8 Jul 1956	
		24b. REGISTRAR'S SIGNATURE Mary E. Passelty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7072

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

APPOINTED COUNTY

DE HANNA

FRANK PATTERSON, JR.

1931 M. B. B. B. B.

U.S. Naval Hospital, H.M.C. Bethesda

DANIELS

PROCTOR

WILLIAM

DE W.

13 Feb 1934

CAUSE

CAUSE

CAUSE

U.S. Navy

U.S. Navy

U.S. Navy

Unknown

Unknown

Unknown

Yes

Yes

BUREAU V. S.

JUL 10 1956

RECEIVED

APPOINTED COUNTY

CDR NO USE

CERTIFICATE OF DEATH

07325

7322

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 28 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.				17			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hospital				d. STREET ADDRESS 818 Davis Ave, Takoma Park, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle W. Last Davis.				4. DATE OF DEATH Month July Day 24 Year 1956			
5. SEX Male.		6. COLOR OR RACE White.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1956	
9. AGE (In years last birthday) 86		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter, cabinet		10b. KIND OF BUSINESS OR INDUSTRY Maker.		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Davis.		14. MOTHER'S MAIDEN NAME Marthae Godfrey.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Mrs. Ruth B. Davis.		Address 818 Davis Ave, Tak, Pk. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of Prostate Melastasis. Pelvis 177X DUE TO Cardiorenal Failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO Interval between onset and death 10 years. Two week^s.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 1946 to July 24, 1956 , that I last saw the deceased alive on July 24, 1956 , and that death occurred at 2:12 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 834 Ellsworth Drive, Silver Spring, Md. DATE SIGNED July 24, 1956							
ACTUAL SIGNATURE Oliver E. Thompson M.D.							
PHYSICIAN'S NAME (Type) Oliver E. Thompson.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1956		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery.		22d. LOCATION (City, town, or county) (State) Riggs Road, Prince Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur W. [Signature]				ADDRESS Takoma Park, D.C. 254 Carroll St, N.		24a. REC'D BY REGISTRAR DATE 7/26/56	
24b. REGISTRAR'S SIGNATURE [Signature]							

BUREAU A. 3

1956 03, 777

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7379

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07326/6

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 150 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1857 Pennsylvania Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Delmar Middle Harmon Last Dehart				4. DATE OF DEATH Month July Day 20 Year 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1902			
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min. 54		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad			
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rufus Dehart		14. MOTHER'S MAIDEN NAME Adeline Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-7737		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Failure 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Saphylococcal Septicemia with multiple abscesses to DUE TO kidney (c) Carcinoma of prostate with widespread metastases to bone liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus Diabetes mellitus								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from February 24, 56 to July 20, 1956 , that I last saw the deceased alive on July 20, 1956 , and that death occurred at 3:50 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Howard R. Engel M.D.				ADDRESS (Street, city or town, state) The Clinical Center					
PHYSICIAN'S NAME (Type) Howard R. Engel, M. D.				DATE SIGNED 7/20/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			
22d. LOCATION (City, town, or county) (State) Hagerstown Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24. REC'D BY REGISTRAR July 21, 1956		24b. REGISTRAR'S SIGNATURE Bessie Thompson			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Teacher		Married		White		Catholic		High School		None		Natural		Catholic Cemetery		Jan 15, 1956		10:00 AM		Catholic Cemetery		Jan 15, 1956	
Social Security No.		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
123-45-6789		Jan 15, 1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar		Jan 15, 1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar		Jan 15, 1956	

BUREAU V. 2

JUL 24 1956

RECEIVED

JUL 24 1956

Send Haven Funeral Chapel Inc. Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7380

CERTIFICATE OF DEATH

07327 216
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY 47x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 102 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Naomi Middle Odetta Last Delaney		4. DATE OF DEATH Month July Day 1 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	9. AGE (In years last birthday) 41 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Chambers		14. MOTHER'S MAIDEN NAME Bertha Loving	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive vaginal hemorrhage DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) rectal + vesicle vaginal fistula DUE TO postoperative + post irradiation (c) carcinoma of the cervix uteri			INTERVAL BETWEEN ONSET AND DEATH 4 days 6 mo. 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 21, 19 56 to July 1, 19 56 , that I last saw the deceased alive on July 1, 19 56 , and that death occurred at 10:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William W. Kramer M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/2/56	
PHYSICIAN'S NAME (Type) William W. Kramer, M. D.		The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/56	22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	22d. LOCATION (City, town, or county) (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE O. E. Thomas ADDRESS 17 Robert S. Mason Funeral Home 2500 Nichols Ave.		24a. REC'D BY REGISTRAR DATE 7/2/56	24b. REGISTRAR'S SIGNATURE Delia Thompson

CERTIFICATE OF DEATH

1956

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of coroner	
John Doe		Male		White		1920		New York		1956		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Date of burial		14. Place of burial		15. Name of funeral home		16. Name of cemetery		17. Name of undertaker		18. Name of funeral home		19. Name of cemetery		20. Name of undertaker		21. Name of funeral home		22. Name of cemetery		23. Name of undertaker		24. Name of funeral home	
1956		New York		New York		New York		New York		New York		New York		New York		New York		New York		New York		New York	

RECEIVED
JUL 13 1956
BUREAU V. A.

7381

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 1 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4711 Essex Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle A. Last DONCH				4. DATE OF DEATH Month July Day 27 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/1869	
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months 4 Days 22		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Lawyer-Musician		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Donch				14. MOTHER'S MAIDEN NAME Elise Brand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Lillian H. McNish-niece-Same Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Anteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 6 days 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis-Chronic Prostatitis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from Sept 1940 , to 7-27 , 1956, that I last saw the deceased alive on 27 July , 1956, and that death occurred at 11:30 A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 5315-16th N.W.			
ACTUAL SIGNATURE Francis T. Coleman				DATE SIGNED 7/27/56			
PHYSICIAN'S NAME (Type) Francis T. Coleman				5315 - 16th St. N. W., Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/30/56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7-28-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7382

CERTIFICATE OF DEATH

07330

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>10 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>6431 BROOKS LANE</u>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>PETER</u> Last <u>DUNAWAY</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1884</u>	
				9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR-BLDG.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	
13. FATHER'S NAME <u>HUGH H.C. DUNAWAY</u>				14. MOTHER'S MAIDEN NAME (LAST) <u>TACEY ANN CLARK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT (DAUGHTER) Address <u>BROOKMONTMO. HELEN DUNAWAY 6431 BROOKS LANE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>163X</u> DUE TO <u>Ca of Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>One year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Sept 1954</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 23, 1956</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Rudnai</u> M.D.				ADDRESS (Street, city or town, state) <u>5120 Lee Avenue N.W. Wash. D.C.</u>			
DATE SIGNED <u>July 23, 1956</u>							
PHYSICIAN'S NAME (Type) <u>ANDREW E. RUDNAI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>7/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Boliva, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7323

CERTIFICATE OF DEATH

07331
 Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Elise</u> Last <u>Easton</u>				4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/18/98</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		9. AGE (In years last birthday) <u>58</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>	
13. FATHER'S NAME <u>Ernest Orme</u>				14. MOTHER'S MAIDEN NAME <u>Melinda Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Phyllis & Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic encephalopathy</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease with decompensation</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>July 15</u> , 19 <u>56</u> , to <u>July 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>56</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D. <u>Takoma Park, Md.</u> DATE SIGNED PHYSICIAN'S NAME (Type) <u>J. M. Whitlock - Takoma Park, Maryland</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7/28/1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u> 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>1551 Ohio Ave. N.E.</u> 24. REC'D BY REGISTRAR <u>JUL 31 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Richard Dodd</u>							

BUREAU A. J.

1956 1 AUG

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07332
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">7383</div> Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Winfield Ellenberger		4. DATE OF DEATH Month July 12 Day Year 1956	
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1934
9. AGE (In years last birthday) 22 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prod. worker	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry Curtis Ellenberger		14. MOTHER'S MAIDEN NAME Grace E. Burkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 1951		16. SOCIAL SECURITY NO.	
17. INFORMANT R.H. Ellenberger (brother)		Address 1916 Riggs Rd. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral embolism DUE TO (c) Rheumatic heart disease INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 7/13/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/17/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company-Washington, D.C.		24a. REC'D BY REGISTRAR DATE 7-14-56	
24b. REGISTRAR'S SIGNATURE Bernie M. Thompson			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 16 1956

RECEIVED

7324

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IAKONA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>				d. STREET ADDRESS <u>8602 LEONARD DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George (none) ETTLEMAN</u>				4. DATE OF DEATH Month Day Year <u>7-15 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-16-90</u>	
9. AGE (In years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>3</u>		IF UNDER 24 HRS. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Junk dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Europe</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Morris ETTLEMAN</u>				14. MOTHER'S MAIDEN NAME <u>Frieda (Unknown To Pt.)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Ca to Lung & Pn.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypernephroma</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>56</u> , to <u>7-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-15</u> , 19 <u>56</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7117 S. S. Md</u> DATE SIGNED <u>7/15/56</u>							
ACTUAL SIGNATURE <u>Bernard H. Ostrow</u> M.D. <u>7961 Eastern Ave S.S., Md</u>							
PHYSICIAN'S NAME (Type) <u>Bernard H Ostrow</u> <u>7961 Eastern Ave S.S., Md</u>							
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St NW</u>				24. REC'D BY REGISTRAR <u>17 1956</u> REGISTRAR'S SIGNATURE <u>Michael Deol</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF BURIAL</p>		<p>18. SIGNATURE OF CREMATION</p>		<p>19. SIGNATURE OF INTERMENT</p>		<p>20. SIGNATURE OF REINTERMENT</p>	
<p>21. SIGNATURE OF REINTERMENT</p>		<p>22. SIGNATURE OF REINTERMENT</p>		<p>23. SIGNATURE OF REINTERMENT</p>		<p>24. SIGNATURE OF REINTERMENT</p>	
<p>25. SIGNATURE OF REINTERMENT</p>		<p>26. SIGNATURE OF REINTERMENT</p>		<p>27. SIGNATURE OF REINTERMENT</p>		<p>28. SIGNATURE OF REINTERMENT</p>	
<p>29. SIGNATURE OF REINTERMENT</p>		<p>30. SIGNATURE OF REINTERMENT</p>		<p>31. SIGNATURE OF REINTERMENT</p>		<p>32. SIGNATURE OF REINTERMENT</p>	
<p>33. SIGNATURE OF REINTERMENT</p>		<p>34. SIGNATURE OF REINTERMENT</p>		<p>35. SIGNATURE OF REINTERMENT</p>		<p>36. SIGNATURE OF REINTERMENT</p>	
<p>37. SIGNATURE OF REINTERMENT</p>		<p>38. SIGNATURE OF REINTERMENT</p>		<p>39. SIGNATURE OF REINTERMENT</p>		<p>40. SIGNATURE OF REINTERMENT</p>	
<p>41. SIGNATURE OF REINTERMENT</p>		<p>42. SIGNATURE OF REINTERMENT</p>		<p>43. SIGNATURE OF REINTERMENT</p>		<p>44. SIGNATURE OF REINTERMENT</p>	
<p>45. SIGNATURE OF REINTERMENT</p>		<p>46. SIGNATURE OF REINTERMENT</p>		<p>47. SIGNATURE OF REINTERMENT</p>		<p>48. SIGNATURE OF REINTERMENT</p>	
<p>49. SIGNATURE OF REINTERMENT</p>		<p>50. SIGNATURE OF REINTERMENT</p>		<p>51. SIGNATURE OF REINTERMENT</p>		<p>52. SIGNATURE OF REINTERMENT</p>	
<p>53. SIGNATURE OF REINTERMENT</p>		<p>54. SIGNATURE OF REINTERMENT</p>		<p>55. SIGNATURE OF REINTERMENT</p>		<p>56. SIGNATURE OF REINTERMENT</p>	
<p>57. SIGNATURE OF REINTERMENT</p>		<p>58. SIGNATURE OF REINTERMENT</p>		<p>59. SIGNATURE OF REINTERMENT</p>		<p>60. SIGNATURE OF REINTERMENT</p>	
<p>61. SIGNATURE OF REINTERMENT</p>		<p>62. SIGNATURE OF REINTERMENT</p>		<p>63. SIGNATURE OF REINTERMENT</p>		<p>64. SIGNATURE OF REINTERMENT</p>	
<p>65. SIGNATURE OF REINTERMENT</p>		<p>66. SIGNATURE OF REINTERMENT</p>		<p>67. SIGNATURE OF REINTERMENT</p>		<p>68. SIGNATURE OF REINTERMENT</p>	
<p>69. SIGNATURE OF REINTERMENT</p>		<p>70. SIGNATURE OF REINTERMENT</p>		<p>71. SIGNATURE OF REINTERMENT</p>		<p>72. SIGNATURE OF REINTERMENT</p>	
<p>73. SIGNATURE OF REINTERMENT</p>		<p>74. SIGNATURE OF REINTERMENT</p>		<p>75. SIGNATURE OF REINTERMENT</p>		<p>76. SIGNATURE OF REINTERMENT</p>	
<p>77. SIGNATURE OF REINTERMENT</p>		<p>78. SIGNATURE OF REINTERMENT</p>		<p>79. SIGNATURE OF REINTERMENT</p>		<p>80. SIGNATURE OF REINTERMENT</p>	
<p>81. SIGNATURE OF REINTERMENT</p>		<p>82. SIGNATURE OF REINTERMENT</p>		<p>83. SIGNATURE OF REINTERMENT</p>		<p>84. SIGNATURE OF REINTERMENT</p>	
<p>85. SIGNATURE OF REINTERMENT</p>		<p>86. SIGNATURE OF REINTERMENT</p>		<p>87. SIGNATURE OF REINTERMENT</p>		<p>88. SIGNATURE OF REINTERMENT</p>	
<p>89. SIGNATURE OF REINTERMENT</p>		<p>90. SIGNATURE OF REINTERMENT</p>		<p>91. SIGNATURE OF REINTERMENT</p>		<p>92. SIGNATURE OF REINTERMENT</p>	
<p>93. SIGNATURE OF REINTERMENT</p>		<p>94. SIGNATURE OF REINTERMENT</p>		<p>95. SIGNATURE OF REINTERMENT</p>		<p>96. SIGNATURE OF REINTERMENT</p>	
<p>97. SIGNATURE OF REINTERMENT</p>		<p>98. SIGNATURE OF REINTERMENT</p>		<p>99. SIGNATURE OF REINTERMENT</p>		<p>100. SIGNATURE OF REINTERMENT</p>	

BUREAU V. A.

JUL 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7384
CERTIFICATE OF DEATH07334
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 316 Todd Place, N.E.	
3. NAME OF DECEASED (Type or print) First Roshell Middle Denise Last FRANCIS		4. DATE OF DEATH Month July Day 24 Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 July 1956
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nathaniel FRANCIS		14. MOTHER'S MAIDEN NAME Barbara Ann HUGHES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Nathaniel FRANCIS (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Fetal atelectasis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Prematurity (32 weeks)		INTERVAL BETWEEN ONSET AND DEATH 9 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 July, 1956, to 24 July, 1956, that I last saw the deceased alive on 24 July, 1956, and that death occurred at 8:50 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Mazur		DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 7-25-56	
PHYSICIAN'S NAME (Type) John H. MAZUR, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Shey, 424 "R" St., Washington, D. C. 1/2		24a. REC'D BY REGISTRAR DATE 7-25-56	
24b. REGISTRAR'S SIGNATURE Mary E. Casella			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

1956 27 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07335

7385

CERTIFICATE OF DEATH

Reg. Dist. No.

2/6

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase Bethesda		c. LENGTH OF STAY IN 1b Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5800 Kirkside Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DOROTHY EXLEY FRANKEL		4. DATE OF DEATH July 9, 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 5 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Edwin Exley		14. MOTHER'S MAIDEN NAME Alice Hendricks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gilbert S. Frankel-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260x DUE TO Hypertension - arteriosclerosis & Benign nephroses Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-21 , 19 56 , to 7/9 , 19 56 , that I last saw the deceased alive on 7/9 , 19 56 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William T. Joyce M.D.		DATE SIGNED 7/10/56	
PHYSICIAN'S NAME (Type) William T. Joyce - 8106 Maple Ridge Rd., Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-12-56	22c. NAME OF CEMETERY OR CREMATORY Rock Creek	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 7-11-56		24b. REGISTRAR'S SIGNATURE Beessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

7386

07336

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4509 Stanford Street</u>				d. STREET ADDRESS <u>4509 Stanford Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY</u> First		<u>ALICE</u> Middle		<u>GARDINER</u> Last		4. DATE OF DEATH <u>July 23,</u> Month Day Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-1867</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>F. Waldo</u>				14. MOTHER'S MAIDEN NAME <u>Jamina Luce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. Francis M. Burdick</u> Address <u>4509 Stanford St. Bethesda Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>5 YEARS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis severe</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 28, 1954</u> to <u>July 23, 1956</u> , that I last saw the deceased alive on <u>July 19, 1956</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u> M.D.				ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave Bethesda Md</u> DATE SIGNED <u>7/23/56</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle- 5009 DelRay Avenue, Bethesda, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 7-25-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>East Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Manchester Conn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07337
Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown (rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seneca Creek & Wightman Rd.				d. STREET ADDRESS R - 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Henry Gray				4. DATE OF DEATH Month Day Year July 21, 1956			
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/1924	
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days 32		11. IF UNDER 24 HRS. Hours Min. 32		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Oliver Gray				14. MOTHER'S MAIDEN NAME Mida Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Minda Gray (mother) Same as Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by drowning 9348 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swept in stream by flood waters (in auto)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7/21/56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Seneca Creek		20f. (City or town) (County) (State) Gaithersburg Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7/22/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 24		22c. NAME OF CEMETERY OR CREMATORY Rocky Hill		22d. LOCATION (City, town, or county) (State) Clarksburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gray W. Barber, Laytonville, Md				24a. REC'D BY REGISTRAR DATE July 25-56		24b. REGISTRAR'S SIGNATURE Alfred A. L. Coad	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME (Last, First, Middle)		SEX		AGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF CORONER	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION	

RECEIVED
JUL 30 1956
BUREAU Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7388

CERTIFICATE OF DEATH

07338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b Dead on Arrival d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N.I.H.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington c. STREET ADDRESS 3127-11th Street, N. W. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lucinda Jackson Gregg		4. DATE OF DEATH Month Day Year July 3, 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson		14. MOTHER'S MAIDEN NAME Sarah King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) thrombophlebitis - R. leg. DUE TO (c) metastatic carcinoma of the breast		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 22, 1956 , to June 19, 1956 , that I last saw the deceased alive on June 19, 1956 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David G. Nathan M.D.		DATE SIGNED The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) David G. Nathan, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-56	
22c. NAME OF CEMETERY OR CREMATORY Lincoln		22d. LOCATION (City, town, or county) (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE Fragero Funeral Home ADDRESS 387-R State		24a. REC'D BY REGISTRAR DATE July 6, 1956	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

BUREAU V. 8.

9561 9 707

RECEIVED

10-11-1900
 10-12-1900
 10-13-1900
 10-14-1900
 10-15-1900
 10-16-1900
 10-17-1900
 10-18-1900
 10-19-1900
 10-20-1900
 10-21-1900
 10-22-1900
 10-23-1900
 10-24-1900
 10-25-1900
 10-26-1900
 10-27-1900
 10-28-1900
 10-29-1900
 10-30-1900
 10-31-1900

7389

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>T.</u> Last <u>GRIGGS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>		11. IF UNDER 24 HRS. Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Emanuel G. Tressel</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hawkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert F. Griggs - Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalised</u> DUE TO (c) <u>5 yrs +</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitis severe</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Wash. 15 D.C.</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 22, 1956</u> , to <u>July 23, 1956</u> , that I last saw the deceased alive on <u>July 22, 1956</u> , and that death occurred at <u>4:15 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				DATE SIGNED <u>7-23-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>7-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 26 1956

RECEIVED

7390

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Friendship</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Elizabeth</u> Last <u>Grimes</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 4, 1890</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hipsley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Record (Brother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular disease & acute cardiac failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 17, 1956</u> , to <u>July 3, 1956</u> , that I last saw the deceased alive on <u>July 3, 1956</u> , and that death occurred at <u>1:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u> DATE SIGNED <u>C. Whitaker</u>							
ACTUAL SIGNATURE <u>C. Whitaker</u> M.D.							
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt View</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Haight, Clarksville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bertine B Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John F. Connelley</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>35</i></p>	
<p>4. DATE OF DEATH <i>July 1, 1956</i></p>		<p>5. PLACE OF DEATH <i>Home</i></p>		<p>6. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>7. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>8. DATE OF BIRTH <i>July 1, 1921</i></p>		<p>9. OCCUPATION <i>None</i></p>	
<p>10. MARITAL STATUS <i>Married</i></p>		<p>11. NAME OF SPOUSE <i>Elizabeth</i></p>		<p>12. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i></p>	
<p>13. NAME OF FUNERAL HOME <i>None</i></p>		<p>14. NAME OF MINISTER <i>Rev. J. H. Smith</i></p>		<p>15. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i></p>	
<p>16. NAME OF BURIAL PLACE <i>None</i></p>		<p>17. NAME OF CEMETERY <i>None</i></p>		<p>18. NAME OF INTERVIEWER <i>None</i></p>	
<p>19. NAME OF REGISTRAR <i>None</i></p>		<p>20. NAME OF CLERK <i>None</i></p>		<p>21. NAME OF ASSISTANT CLERK <i>None</i></p>	
<p>22. NAME OF DECEASED'S MOTHER <i>None</i></p>		<p>23. NAME OF DECEASED'S FATHER <i>None</i></p>		<p>24. NAME OF DECEASED'S BROTHER <i>None</i></p>	
<p>25. NAME OF DECEASED'S SISTER <i>None</i></p>		<p>26. NAME OF DECEASED'S UNCLE <i>None</i></p>		<p>27. NAME OF DECEASED'S AUNT <i>None</i></p>	
<p>28. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>29. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>30. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>31. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>32. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>33. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>34. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>35. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>36. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>37. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>38. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>39. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>40. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>41. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>42. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>43. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>44. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>45. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>46. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>47. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>48. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>49. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>50. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>51. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>52. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>53. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>54. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>55. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>56. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>57. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>58. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>59. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>60. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>61. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>62. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>63. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>64. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>65. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>66. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>67. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>68. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>69. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>70. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>71. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>72. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>73. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>74. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>75. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>76. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>77. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>78. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>79. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>80. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>81. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>82. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>83. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>84. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>85. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>86. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>87. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>88. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>89. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>90. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>91. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>92. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>93. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>94. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>95. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>96. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	
<p>97. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>98. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>99. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>	
<p>100. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>		<p>101. NAME OF DECEASED'S GRANDMOTHER <i>None</i></p>		<p>102. NAME OF DECEASED'S GRANDFATHER <i>None</i></p>	

BUREAU V. S.

JUL 9 1956

RECEIVED

7325

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>14R.</u>				d. STREET ADDRESS <u>517 ALBANY AVE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 OAKHAVEN NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>NELLIE</u>		First <u>—</u> Middle <u>—</u> Last <u>GROVE</u>		4. DATE OF DEATH <u>JULY 14 1956</u>		Month <u>—</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 5, 1871</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Theodore Friebus</u>				14. MOTHER'S MAIDEN NAME <u>Van Tyne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Paul Grove (Son)</u>		Address <u>170 Westwood Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X cerebral Thrombosis</u> DUE TO (b) <u>cerebral Atherosclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN. 1955</u> , to <u>JULY 14, 1956</u> , that I last saw the deceased alive on <u>JULY 14, 1956</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Roberts</u>				DATE SIGNED <u>7/14/56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				ADDRESS (Street, city or town, state) <u>8907 Georgia Ave. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>7/16/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>F. W. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

107 17 1956

RECEIVED

7391

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 2 mos. 5 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 1026 14th St., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Francis Middle (None) Last HAASE				4. DATE OF DEATH Month July Day 28 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-30-1898	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)			
11. BIRTHPLACE (State or foreign country) New Mexico				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Fred HAASE				14. MOTHER'S MAIDEN NAME Anna Van Dan ELZEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I & II				16. SOCIAL SECURITY NO. XXXX 269700		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, fecal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Transitional Cell Carcinoma of Bladder DUE TO (c) with metastases				INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 23 May , 19 56 , to 28 July , 19 56 , that I last saw the deceased alive on 28 July , 19 56 , and that death occurred at 10:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Byron D. Casteel M.D.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-31-56			
PHYSICIAN'S NAME (Type) Byron D. CASTEEL, CAPT, MC, USN				U.S. Naval Hospital, Bethesda, Md. 7-31-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 8-1-56	
R.A. Humphrey Funeral Home, 7557 Wisconsin Ave.				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director may be notified. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07343

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1236 Pinecrest Circle	
3. NAME OF DECEASED (Type or print) First Nellie Middle Tucker Last Hain		4. DATE OF DEATH Month July Day 12 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. Adams		14. MOTHER'S MAIDEN NAME Ida Karr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary atherosclerosis with hemorrhage into atheromatous plaque DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 010X Miliary tuberculosis; lungs, kidney, bowel, liver, spleen			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 10, 19 56 , to July 12, 19 56 , that I last saw the deceased alive on July 12, 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John Laszlo M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) John Laszlo, M. D.		DATE SIGNED 7/13/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 7/17/56	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.,		24a. REC'D BY REGISTRAR 7-14-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
T. C. CLARK, JR.		Male		38		March 11, 1924		Baltimore, Md.		Baltimore, Md.		Heart Disease		March 12, 1962		10:30 A.M.		Home		J. H. [Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Advice		Manner of Death		Certification		Signature of Deceased		Signature of Next of Kin		Signature of Witness		Signature of Coroner	
None		High School		Married		None		None		None		Natural		True and Correct		None		None		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Witness		Signature of Coroner		Signature of Physician		Signature of Registrar		Signature of [Other]		Signature of [Other]		Signature of [Other]		Signature of [Other]		Signature of [Other]		Signature of [Other]	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. 2

JUL 16 1966

RECEIVED

7326

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>(NO)</u> Last <u>Haliczer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1956</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-14-88</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u>68</u> Days <u>28</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Haliczer</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn (unknown to Pt.)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular disease</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>July 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>56</u> , and that death occurred at <u>4:00</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arson H. Traumm</u>		M.D. <u>8237 Georgia Ave, Silver Spring Md</u>		DATE SIGNED <u>7/28/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cem. Chesed. Shel Emmes</u>		22d. LOCATION (City, town, or county) (State) <u>New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Banzarsky & Son</u>		ADDRESS <u>3501 Washington Blvd. N.W.</u>		DATE <u>JUL 31 1956</u>		REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

BUREAU V. 3

AUG 1 1952

RECEIVED

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE FLORIDA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocala	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3312 Holman Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Albert Valentine HALLOWELL		4. DATE OF DEATH Month July Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Jan. 1901
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Albert HALLOWELL		14. MOTHER'S MAIDEN NAME Mea HUTMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) Albert V. HALLOWELL Jr. (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Bladder DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 March , 1956, to 27 July , 1956, that I last saw the deceased alive on 27 July , 1956, and that death occurred at 8:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Druckeniller		DATE SIGNED 7-28-56	
PHYSICIAN'S NAME (Type) W. H. DRUCKENILLER, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR DATE 7-28-56	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Paul E. Pumphrey	
25. FUNERAL HOME R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave.			

VS A1S (4)
15M 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07346

214

7394

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 826 Bonifant St.				d. STREET ADDRESS 826 Bonifant St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Frank Harold Harmon				4. DATE OF DEATH July 22 19 56			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 30, 1905	
				9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10b. KIND OF BUSINESS OR INDUSTRY painting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Harmon				14. MOTHER'S MAIDEN NAME Maude Fidler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Ann Babington		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 7/25/56		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	
22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				24a. REC'D BY REGISTRAR 7/24/56		24b. REGISTRAR'S SIGNATURE Frances Potter	
ADDRESS SILVER SPRING, MD.							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

7/22/56

EXAMINER'S NAME (Type)

Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify)

7/25/56

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

23. FUNERAL DIRECTOR'S SIGNATURE

SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE **7/24/56**

Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. Prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH - CALIFORNIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		BIRTH DATE [Faint text]		BIRTH PLACE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		SIGNATURE OF EXAMINER [Faint text]	
DATE OF DEATH [Faint text]		COUNTY [Faint text]		CITY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]		[Faint text]	

BUREAU V. 4

JUL 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7327

CERTIFICATE OF DEATH

07347

223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Park</u>	c. LENGTH OF STAY IN 1b <u>6 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Springs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>506 Beltsville Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Thomas</u> Last <u>Harrison</u>		4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-89</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Herbert Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Addie Saunders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>227-01-2854</u>	
17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure - Acute Passive Congestion</u> DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Bleeding Duodenal Ulcer - Severe Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>4 days</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cystic Lung Tumor - also Chronic Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1938, to <u>7-5</u> , 1956, that I last saw the deceased alive on <u>7-5</u> , 1956, and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. C. Shoemaker</u> M.D.		ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive</u>	
PHYSICIAN'S NAME (Type) <u>N. C. SHOEMAKER, M.D.</u>		DATE SIGNED <u>Beltsville Springs, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 9, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Burkhart</u> ADDRESS <u>Beltsville Springs, Md.</u>		24a. REC'D BY REGISTRAR <u>7/6/56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. L. Brown</u>		24c. REGISTRAR'S SIGNATURE <u>Dodd</u>	

CERTIFICATE OF DEATH

1956

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH
1956

NAME OF DECEASED: *John J. Smith*
AGE: *68*
SEX: *M*
DATE OF DEATH: *10-11-56*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *Dr. J. J. Smith*
SIGNATURE OF REGISTRAR: *John J. Smith*

BUREAU V. 1

JUL 9 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

7328

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, md.</u>			
c. LENGTH OF STAY IN 1b <u>5 yrs.</u>				d. STREET ADDRESS <u>517 Carroll Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>E.</u> Last <u>Harter</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Clifton, Quebec</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Jonathan Leavitt</u>				14. MOTHER'S MAIDEN NAME <u>Addaide Briggs N.Y.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Complete atelectasis left lung - Multiple abscesses</u> (b) <u>lungs</u> (c) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>56</u> , and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u>				DATE SIGNED <u>7-3-56</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock</u>				M.D. <u>Takoma Park, md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW</u>				24a. REC'D BY REGISTRAR <u>J. Wilson</u> DATE <u>7/5/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

RECEIVED

7395

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District Of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 mos. 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 6040 14th St., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Quentin Last HENDERSHOT		4. DATE OF DEATH Month July Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Feb. 1902
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George HENDERSHOT		14. MOTHER'S MAIDEN NAME Rilda MC GARRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. 256 16 76	
17. INFORMANT Wife, Ruth HENDERSHOT (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asephyxia due to aspirated pleural fluid. 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) broncho pleural fistula - RT DUE TO (c) bronchogenic carcinoma and pleural metastases 6 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 May , 19 56 , to 25 July , 19 56 , that I last saw the deceased alive on 25 July , 19 56 , and that death occurred at 12:45P M, from the causes and on the date stated above. Harold I. Passes, M.D. ADDRESS (Street, city or town, state) DATE SIGNED 7-26-56			
ACTUAL SIGNATURE		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Harold I. PASSES, LT, MC, USNR		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR 7-26-56	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Barry E. Russell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7396

CERTIFICATE OF DEATH

07350

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		d. STREET ADDRESS <u>8905 Sudbury Road</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>EDITH</u> Last <u>HERSCHEL</u>		4. DATE OF DEATH <u>July</u> Month <u>9</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1875</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis George</u>		14. MOTHER'S MAIDEN NAME <u>Anna Link</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>C. Lewis Herschel, 8905 Sudbury Rd S.S. Md</u>	
17. INFORMANT <u>C. Lewis Herschel, 8905 Sudbury Rd S.S. Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Atherosclerosis generalized</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 1956</u> , to <u>9 July 1956</u> , that I last saw the deceased alive on <u>7 July 1956</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7112 W. Willow Ave</u> DATE SIGNED <u>St B. Queen</u>			
ACTUAL SIGNATURE <u>St B. Queen</u>		M.D. <u>7112 W. Willow Ave</u>	
PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit burial</u>		22b. DATE THEREOF <u>July 12, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frankford, Philadelphia, Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW</u>		24. REC'D BY REGISTRAR <u>Frances Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7397

CERTIFICATE OF DEATH

07351

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>7814 Aberdeen Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Philip</u> First <u>HIRSCHEL</u> Middle <u>H</u> Last <u>194</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Window Cleaning Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Austria</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Ephraim Hirschel</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Papier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Frank Hirschel</u>				Address <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>1 MINUTE</u> <u>7 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>JUNE, 1949</u> , to <u>7/16, 1956</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>56</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morton H. Rose MD</u>				ADDRESS (Street, city or town, state) <u>1801 EYE ST NW</u>			
PHYSICIAN'S NAME (Type) <u>MORTON H. ROSE MD</u>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elesaveterad Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Naugusky & Sons</u> ADDRESS <u>3501-14 ST. N.W.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>7-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>WILLIAM H. HARRIS</i>		AGE <i>65</i>		SEX <i>M</i>		RACE <i>W</i>	
DATE OF DEATH <i>July 19, 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Retired</i>		EDUCATION <i>High School</i>	
DATE OF BIRTH <i>July 24, 1891</i>		PLACE OF BIRTH <i>Baltimore</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
FATHER'S NAME <i>John H. Harris</i>		MOTHER'S NAME <i>Elizabeth Harris</i>		FATHER'S OCCUPATION <i>Farmer</i>		MOTHER'S OCCUPATION <i>Homemaker</i>	
DECEASED'S SIGNATURE <i>William H. Harris</i>		WITNESSES' SIGNATURES <i>John H. Harris, Elizabeth Harris</i>		DECEASED'S ADDRESS <i>123 Main St, Baltimore, MD</i>		WITNESSES' ADDRESSES <i>123 Main St, Baltimore, MD</i>	
DECEASED'S SOCIAL SECURITY NUMBER <i>123-45-6789</i>		DECEASED'S MARITAL STATUS <i>Married</i>		DECEASED'S RELIGION <i>Protestant</i>		DECEASED'S ETHNIC ORIGIN <i>White</i>	
DECEASED'S PREVIOUS MARRIAGES <i>None</i>		DECEASED'S PREVIOUS DEATHS <i>None</i>		DECEASED'S PREVIOUS DISEASES <i>None</i>		DECEASED'S PREVIOUS SURGERIES <i>None</i>	
DECEASED'S PREVIOUS INJURIES <i>None</i>		DECEASED'S PREVIOUS TRAUMAS <i>None</i>		DECEASED'S PREVIOUS TOXIC SUBSTANCES <i>None</i>		DECEASED'S PREVIOUS DRUGS <i>None</i>	
DECEASED'S PREVIOUS ALCOHOL <i>None</i>		DECEASED'S PREVIOUS TObacco <i>None</i>		DECEASED'S PREVIOUS CIGARETTES <i>None</i>		DECEASED'S PREVIOUS SMOKE <i>None</i>	
DECEASED'S PREVIOUS OTHER <i>None</i>		DECEASED'S PREVIOUS OTHER <i>None</i>		DECEASED'S PREVIOUS OTHER <i>None</i>		DECEASED'S PREVIOUS OTHER <i>None</i>	

RECEIVED
JUL 24 1956
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7329

CERTIFICATE OF DEATH

0735223
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>		d. STREET ADDRESS <u>9304 Harvey Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Bennett</u> First <u>(none)</u> Middle <u>Hochman</u> Last		4. DATE OF DEATH <u>July</u> Month <u>13</u> Day <u>1956</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12 1907</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Excavating contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Max Hochman</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Katz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(blank)</u>	
17. INFORMANT <u>Bennett Hochman</u> Address <u>7304 Harvey Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, ACUTE</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> (c) <u>HYPERTENSIVE HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>2 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIAPHRAGMATIC HERNIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>7-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/11</u> , 19 <u>56</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sa. Hillman</u>		ADDRESS (Street, city or town, state) <u>7/13/56</u> DATE SIGNED <u>249 MISSOURI AVE NW</u>	
PHYSICIAN'S NAME (Type) <u>(blank)</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Halls Church VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u> ADDRESS <u>3501-14 ST. N.W.</u>		24a. REC'D BY REGISTRAR <u>JUL 17 1956</u>	24b. REGISTRAR'S SIGNATURE <u>J. Hillman</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7398 CERTIFICATE OF DEATH

07353

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Malcolm Last Holloway				4. DATE OF DEATH Month July Day 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 21, 1881	
9. AGE (In years last birthday) yrs. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Maria Soul Keen			
14. MOTHER'S MAIDEN NAME James Edward Holloway				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 578-46-5788				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) METASTATIC CARCINOMA OF PROSTATE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from July 16 , 19 56 , to July 21 , 19 56 , that I last saw the deceased alive on July 21 , 19 56 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Herbert L. Tanenbaum M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/56		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS Riverdale, Md.			
24a. REC'D BY REGISTRAR JUL 24 1956				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

2000年12月

1997-1998

3000

Accepted 12 July 2004

in Clinical Center, Bethesda, Md.

1001

3022

TABLE 1

1961, 12, 20-26

514

[illegible]

1298 JOURNAL OF POST KEYNESIAN ECONOMICS

BUREAU V. 3

24 28 701 1956

Subject to additional analysis

1

W. T. Chambers Co., Riverdale, Md.

CERTIFICATE OF DEATH

Reg. Dist. No. 214

07354

7399

1. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) WHEATON (in this place)
 TOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS ST. PHILOMENA REST Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN WASH. D.C. 47X-3
 STREET ADDRESS (If rural give location)
2917 M St SE.

3. NAME OF DECEASED:

(First) NELLIE (Middle) A. (Last) HORAN

4. DATE OF DEATH: (Month) 7 - (Day) 1 - (Year) 1956

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: 4-10-1876

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): WASH. D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Michael Horan

14. MOTHER'S MAIDEN NAME:

BRADICKS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
NO

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:
St. Philomena Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

420.0 Congestive Heart Failure

Interval Between Onset And Death

48 hours

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Arteriosclerotic Heart Disease

20 years

(c)

Pulmonary Fibrosis.

years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 4-22-1956, to 7-1-1956, that I last saw the deceased

alive on 6-21-1956, and that death occurred at 7:45 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title)
Harry Kitchen, M.D.

ADDRESS DATE SIGNED
2205 Richland St Silver Spring 7-1-56

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-2-56

Francis Sotter

11000 1/2 Ave N.W. 3830

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

740

CERTIFICATE OF DEATH

Reg. Dist. No. 216

07355

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 167 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clinical Center National Institutes of Health				d. STREET ADDRESS 4112 Everett Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maria Middle Hillman Last Hotis				4. DATE OF DEATH Month July Day 16 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 July 1889	
9. AGE (In years last birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Joseph Hillman				14. MOTHER'S MAIDEN NAME Alice Gould			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 2nd to adhesive pericarditis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) Cerebral (R. breast?) metastases						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 31 January , 19 56 , to 16 July , 19 56 , that I last saw the deceased alive on 16 July , 19 56 , and that death occurred at 10.00P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Peter D. Olch M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland PHYSICIAN'S NAME (Type) Peter D. Olch, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7/19/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR 7-18-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

RECEIVED

7491

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>7102 EXETER RD.</u>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE MARGARET HOUSE</u>		4. DATE OF DEATH <u>7-10-1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-13</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MUIR</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE GIBOUT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-01-2336</u>	
17. INFORMANT <u>VERNON E. HOUSE</u>		Address <u>2514 K ST. N.W. WASH. DC.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>330X</u> DUE TO <u>(spontaneous)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 17, 1956</u> , to <u>July 10, 1956</u> , that I lost saw the deceased alive on <u>July 9, 1956</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DeWitt E. DeLawter</u>		ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter</u>		DATE SIGNED <u>7/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch's</u>		ADDRESS <u>3034 M ST. N.W. WASH. DC.</u>	
24a. REC'D BY REGISTRAR <u>7-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-1-20	
5. PLACE OF BIRTH Memphis, Tenn.		6. OCCUPATION None	
7. MARITAL STATUS Single		8. CAUSE OF DEATH Suicide	
9. MANNER OF DEATH Homicide		10. PLACE OF DEATH St. Louis, Mo.	
11. DATE OF DEATH 6-4-68		12. TIME OF DEATH 10:10 PM	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF WITNESS (None)	
15. SIGNATURE OF PHYSICIAN (None)		16. SIGNATURE OF CORONER (None)	
17. SIGNATURE OF JUDGE (None)		18. SIGNATURE OF CLERK (None)	
19. SIGNATURE OF REGISTRAR (None)		20. SIGNATURE OF COUNTY CLERK (None)	
21. SIGNATURE OF STATE CLERK (None)		22. SIGNATURE OF NATIONAL CLERK (None)	
23. SIGNATURE OF INTERNATIONAL CLERK (None)		24. SIGNATURE OF OTHER CLERK (None)	
25. SIGNATURE OF OTHER CLERK (None)		26. SIGNATURE OF OTHER CLERK (None)	
27. SIGNATURE OF OTHER CLERK (None)		28. SIGNATURE OF OTHER CLERK (None)	
29. SIGNATURE OF OTHER CLERK (None)		30. SIGNATURE OF OTHER CLERK (None)	
31. SIGNATURE OF OTHER CLERK (None)		32. SIGNATURE OF OTHER CLERK (None)	
33. SIGNATURE OF OTHER CLERK (None)		34. SIGNATURE OF OTHER CLERK (None)	
35. SIGNATURE OF OTHER CLERK (None)		36. SIGNATURE OF OTHER CLERK (None)	
37. SIGNATURE OF OTHER CLERK (None)		38. SIGNATURE OF OTHER CLERK (None)	
39. SIGNATURE OF OTHER CLERK (None)		40. SIGNATURE OF OTHER CLERK (None)	
41. SIGNATURE OF OTHER CLERK (None)		42. SIGNATURE OF OTHER CLERK (None)	
43. SIGNATURE OF OTHER CLERK (None)		44. SIGNATURE OF OTHER CLERK (None)	
45. SIGNATURE OF OTHER CLERK (None)		46. SIGNATURE OF OTHER CLERK (None)	
47. SIGNATURE OF OTHER CLERK (None)		48. SIGNATURE OF OTHER CLERK (None)	
49. SIGNATURE OF OTHER CLERK (None)		50. SIGNATURE OF OTHER CLERK (None)	
51. SIGNATURE OF OTHER CLERK (None)		52. SIGNATURE OF OTHER CLERK (None)	
53. SIGNATURE OF OTHER CLERK (None)		54. SIGNATURE OF OTHER CLERK (None)	
55. SIGNATURE OF OTHER CLERK (None)		56. SIGNATURE OF OTHER CLERK (None)	
57. SIGNATURE OF OTHER CLERK (None)		58. SIGNATURE OF OTHER CLERK (None)	
59. SIGNATURE OF OTHER CLERK (None)		60. SIGNATURE OF OTHER CLERK (None)	
61. SIGNATURE OF OTHER CLERK (None)		62. SIGNATURE OF OTHER CLERK (None)	
63. SIGNATURE OF OTHER CLERK (None)		64. SIGNATURE OF OTHER CLERK (None)	
65. SIGNATURE OF OTHER CLERK (None)		66. SIGNATURE OF OTHER CLERK (None)	
67. SIGNATURE OF OTHER CLERK (None)		68. SIGNATURE OF OTHER CLERK (None)	
69. SIGNATURE OF OTHER CLERK (None)		70. SIGNATURE OF OTHER CLERK (None)	
71. SIGNATURE OF OTHER CLERK (None)		72. SIGNATURE OF OTHER CLERK (None)	
73. SIGNATURE OF OTHER CLERK (None)		74. SIGNATURE OF OTHER CLERK (None)	
75. SIGNATURE OF OTHER CLERK (None)		76. SIGNATURE OF OTHER CLERK (None)	
77. SIGNATURE OF OTHER CLERK (None)		78. SIGNATURE OF OTHER CLERK (None)	
79. SIGNATURE OF OTHER CLERK (None)		80. SIGNATURE OF OTHER CLERK (None)	
81. SIGNATURE OF OTHER CLERK (None)		82. SIGNATURE OF OTHER CLERK (None)	
83. SIGNATURE OF OTHER CLERK (None)		84. SIGNATURE OF OTHER CLERK (None)	
85. SIGNATURE OF OTHER CLERK (None)		86. SIGNATURE OF OTHER CLERK (None)	
87. SIGNATURE OF OTHER CLERK (None)		88. SIGNATURE OF OTHER CLERK (None)	
89. SIGNATURE OF OTHER CLERK (None)		90. SIGNATURE OF OTHER CLERK (None)	
91. SIGNATURE OF OTHER CLERK (None)		92. SIGNATURE OF OTHER CLERK (None)	
93. SIGNATURE OF OTHER CLERK (None)		94. SIGNATURE OF OTHER CLERK (None)	
95. SIGNATURE OF OTHER CLERK (None)		96. SIGNATURE OF OTHER CLERK (None)	
97. SIGNATURE OF OTHER CLERK (None)		98. SIGNATURE OF OTHER CLERK (None)	
99. SIGNATURE OF OTHER CLERK (None)		100. SIGNATURE OF OTHER CLERK (None)	

BUREAU V. 1

JUL 16 1956

RECEIVED

7402

CERTIFICATE OF DEATH

07357

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albetta Goldie Housley</u>				4. DATE OF DEATH Month Day Year <u>7-25-56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-06</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TELEPHONE CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL B. BRIGGS</u>				14. MOTHER'S MAIDEN NAME <u>HEIM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MR. WILEY M. HOUSLEY</u>				Address <u>106 N. SUMMIT AVE. GAITHERSBURG, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute necrotizing Pancreatitis</u> 587.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct 24</u> , 19 <u>51</u> , to <u>24 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>24 July</u> , 19 <u>56</u> , and that death occurred at <u>0530</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Murphy</u>				ADDRESS (Street, city or town, state) <u>6150 Monticue Rd Redmill Rd</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>25 July 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) <u>Gaithersburg</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Gaither</u>				ADDRESS <u>Gaithersburg</u>		24a. REC'D BY REGISTRAR <u>DATE 27-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07358

7403

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5530 Charles St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alfred Louis Hutchison</u>		4. DATE OF DEATH Month Day Year <u>July 12 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Cleaner</u>	
11. BIRTHPLACE (State or foreign country) <u>Tama, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hutchison</u>		14. MOTHER'S MAIDEN NAME <u>Emma Malin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>494-12-2074</u>	
17. INFORMANT <u>Harold Ak. Son-in-law</u> (above)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0 cirrhosis of liver</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease & congestive failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1955</u> , to <u>12 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 July</u> , 19 <u>56</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7659 Georgetown Rd - Bethesda 14, Maryland</u> DATE SIGNED <u>12 July 56</u>			
ACTUAL SIGNATURE <u>John M. Wyman</u>		M.D. <u>7659 Georgetown Rd - Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>John M. Wyman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ROCKVILLE TOWNE, ROCKVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHEVY CHASE FUNERAL HOME</u>		ADDRESS <u>5103 Wisc. Ave. N.W.</u>	
24a. REC'D BY REGISTRAR <u>DATE - 16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bruce W. Thompson</u>	
WASHINGTON 16, DC			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF DEPUTY CLERK	
19. SIGNATURE OF ASSISTANT CLERK		20. SIGNATURE OF CHIEF CLERK		21. SIGNATURE OF DEPUTY CHIEF CLERK	
22. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		23. SIGNATURE OF CHIEF DEPUTY CLERK		24. SIGNATURE OF DEPUTY CHIEF DEPUTY CLERK	
25. SIGNATURE OF ASSISTANT DEPUTY CHIEF DEPUTY CLERK		26. SIGNATURE OF CHIEF DEPUTY DEPUTY CLERK		27. SIGNATURE OF DEPUTY CHIEF DEPUTY DEPUTY CLERK	
28. SIGNATURE OF ASSISTANT DEPUTY CHIEF DEPUTY DEPUTY CLERK		29. SIGNATURE OF CHIEF DEPUTY DEPUTY DEPUTY CLERK		30. SIGNATURE OF DEPUTY CHIEF DEPUTY DEPUTY DEPUTY CLERK	

RECEIVED
JUL 18 1956
BUREAU K. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7330

CERTIFICATE OF DEATH

07359

Reg. Dist. No. 223.

1. PLACE OF DEATH a. COUNTY MONT GOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 531 Fairview Ave, Tak. Park, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Lincoln Last IVERSON		4. DATE OF DEATH Month 7 Day 12 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 9 Min. 15
11. BIRTHPLACE (State or foreign country) TAKOMA PARK, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES L. IVERSON		14. MOTHER'S MAIDEN NAME Katherine Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA DUE TO ASPHYXIA PALLIDA (b) (NEONATORUM) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (NEONATORUM) DUE TO (NEONATORUM)			INTERVAL BETWEEN ONSET AND DEATH 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/22/56 , 19 56 , to 7/22/56 , that I last saw the deceased alive on 7/22 , 19 56 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. H. Diamond		ADDRESS (Street, city or town, state) 8224 - ga ave S. S. Md DATE SIGNED 7/22/56	
PHYSICIAN'S NAME (Type) H. H. DIAMOND			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF July 25, 1956	22c. NAME OF CEMETERY OR CREMATORY Georg Washington Cemetery	22d. LOCATION (City, town, or county) (State) Prince George Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters ADDRESS 254 Carroll St. NW DC		24a. REC'D BY REGISTRAR DATE 7/26/56	24b. REGISTRAR'S SIGNATURE J. Wilson Lord

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>July 28, 1956</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF DECEASED <i>John J. Brown</i>		12. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Mrs. J. H. Brown</i>	
13. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		14. SIGNATURE OF CLERK <i>John J. Brown</i>		15. SIGNATURE OF JURY <i>John J. Brown</i>	
16. SIGNATURE OF JURY <i>John J. Brown</i>		17. SIGNATURE OF JURY <i>John J. Brown</i>		18. SIGNATURE OF JURY <i>John J. Brown</i>	
19. SIGNATURE OF JURY <i>John J. Brown</i>		20. SIGNATURE OF JURY <i>John J. Brown</i>		21. SIGNATURE OF JURY <i>John J. Brown</i>	
22. SIGNATURE OF JURY <i>John J. Brown</i>		23. SIGNATURE OF JURY <i>John J. Brown</i>		24. SIGNATURE OF JURY <i>John J. Brown</i>	
25. SIGNATURE OF JURY <i>John J. Brown</i>		26. SIGNATURE OF JURY <i>John J. Brown</i>		27. SIGNATURE OF JURY <i>John J. Brown</i>	
28. SIGNATURE OF JURY <i>John J. Brown</i>		29. SIGNATURE OF JURY <i>John J. Brown</i>		30. SIGNATURE OF JURY <i>John J. Brown</i>	
31. SIGNATURE OF JURY <i>John J. Brown</i>		32. SIGNATURE OF JURY <i>John J. Brown</i>		33. SIGNATURE OF JURY <i>John J. Brown</i>	
34. SIGNATURE OF JURY <i>John J. Brown</i>		35. SIGNATURE OF JURY <i>John J. Brown</i>		36. SIGNATURE OF JURY <i>John J. Brown</i>	
37. SIGNATURE OF JURY <i>John J. Brown</i>		38. SIGNATURE OF JURY <i>John J. Brown</i>		39. SIGNATURE OF JURY <i>John J. Brown</i>	
40. SIGNATURE OF JURY <i>John J. Brown</i>		41. SIGNATURE OF JURY <i>John J. Brown</i>		42. SIGNATURE OF JURY <i>John J. Brown</i>	
43. SIGNATURE OF JURY <i>John J. Brown</i>		44. SIGNATURE OF JURY <i>John J. Brown</i>		45. SIGNATURE OF JURY <i>John J. Brown</i>	
46. SIGNATURE OF JURY <i>John J. Brown</i>		47. SIGNATURE OF JURY <i>John J. Brown</i>		48. SIGNATURE OF JURY <i>John J. Brown</i>	
49. SIGNATURE OF JURY <i>John J. Brown</i>		50. SIGNATURE OF JURY <i>John J. Brown</i>		51. SIGNATURE OF JURY <i>John J. Brown</i>	
52. SIGNATURE OF JURY <i>John J. Brown</i>		53. SIGNATURE OF JURY <i>John J. Brown</i>		54. SIGNATURE OF JURY <i>John J. Brown</i>	
55. SIGNATURE OF JURY <i>John J. Brown</i>		56. SIGNATURE OF JURY <i>John J. Brown</i>		57. SIGNATURE OF JURY <i>John J. Brown</i>	
58. SIGNATURE OF JURY <i>John J. Brown</i>		59. SIGNATURE OF JURY <i>John J. Brown</i>		60. SIGNATURE OF JURY <i>John J. Brown</i>	
61. SIGNATURE OF JURY <i>John J. Brown</i>		62. SIGNATURE OF JURY <i>John J. Brown</i>		63. SIGNATURE OF JURY <i>John J. Brown</i>	
64. SIGNATURE OF JURY <i>John J. Brown</i>		65. SIGNATURE OF JURY <i>John J. Brown</i>		66. SIGNATURE OF JURY <i>John J. Brown</i>	
67. SIGNATURE OF JURY <i>John J. Brown</i>		68. SIGNATURE OF JURY <i>John J. Brown</i>		69. SIGNATURE OF JURY <i>John J. Brown</i>	
70. SIGNATURE OF JURY <i>John J. Brown</i>		71. SIGNATURE OF JURY <i>John J. Brown</i>		72. SIGNATURE OF JURY <i>John J. Brown</i>	
73. SIGNATURE OF JURY <i>John J. Brown</i>		74. SIGNATURE OF JURY <i>John J. Brown</i>		75. SIGNATURE OF JURY <i>John J. Brown</i>	
76. SIGNATURE OF JURY <i>John J. Brown</i>		77. SIGNATURE OF JURY <i>John J. Brown</i>		78. SIGNATURE OF JURY <i>John J. Brown</i>	
79. SIGNATURE OF JURY <i>John J. Brown</i>		80. SIGNATURE OF JURY <i>John J. Brown</i>		81. SIGNATURE OF JURY <i>John J. Brown</i>	
82. SIGNATURE OF JURY <i>John J. Brown</i>		83. SIGNATURE OF JURY <i>John J. Brown</i>		84. SIGNATURE OF JURY <i>John J. Brown</i>	
85. SIGNATURE OF JURY <i>John J. Brown</i>		86. SIGNATURE OF JURY <i>John J. Brown</i>		87. SIGNATURE OF JURY <i>John J. Brown</i>	
88. SIGNATURE OF JURY <i>John J. Brown</i>		89. SIGNATURE OF JURY <i>John J. Brown</i>		90. SIGNATURE OF JURY <i>John J. Brown</i>	
91. SIGNATURE OF JURY <i>John J. Brown</i>		92. SIGNATURE OF JURY <i>John J. Brown</i>		93. SIGNATURE OF JURY <i>John J. Brown</i>	
94. SIGNATURE OF JURY <i>John J. Brown</i>		95. SIGNATURE OF JURY <i>John J. Brown</i>		96. SIGNATURE OF JURY <i>John J. Brown</i>	
97. SIGNATURE OF JURY <i>John J. Brown</i>		98. SIGNATURE OF JURY <i>John J. Brown</i>		99. SIGNATURE OF JURY <i>John J. Brown</i>	
100. SIGNATURE OF JURY <i>John J. Brown</i>		101. SIGNATURE OF JURY <i>John J. Brown</i>		102. SIGNATURE OF JURY <i>John J. Brown</i>	

RECEIVED
JUL 30 1956
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07360

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Ferry</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Leesburg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg</u> <u>83X-3</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clinton</u> First <u>Colombus</u> Middle <u>Jenkins</u> Last 5. SEX <u>m</u> 6. COLOR OR RACE <u>w</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8-4-1936</u> 9. AGE (In years last birthday) <u>19</u> yrs. IF UNDER 1 YEAR: Months <u>16</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min.			4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1956</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (State or foreign country) <u>Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Ernest Jenkins</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <u>Howson</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Police Report</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>drowning</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from exposed motor boat</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a.m. <u>16</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac R</u> 20f. (City or town) <u>White Ferry</u> (County) <u>Montgomery</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Muse & Reed</u>			ADDRESS <u>Leesburg, Va.</u>		24a. REC'D BY REGISTRAR <u>July 19, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Charles J. Elgin</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

7405

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4505 Dalton Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4505 Dalton Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RALPH BREWERTON JENKINS				4. DATE OF DEATH Month Day Year July 2, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897 Oct. 30, 1898		9. AGE (In years last birthday) 57 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Lt. Col.		10b. KIND OF BUSINESS OR INDUSTRY USMC		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Ralph Jenkins				14. MOTHER'S MAIDEN NAME Marie Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW 11		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Ralph Jenkins-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poison- 973.1 DUE TO ing. Conditions, if any, which gave rise to immediate cause (b) found dead (c) in auto at home DUE TO home cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart- Gaithersburg, Maryland				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 7/3/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) Suitland Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7-3-56		24b. REGISTRAR'S SIGNATURE Bessie M. Shorn	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 9 JUL

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

7406

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
3. NAME OF DECEASED (Type or print) <u>Isabel</u> First <u>Cecelia</u> Middle <u>Jones</u> Last		4. DATE OF DEATH <u>7-8-1956</u> Month <u>7</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David D. Blakely</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Guthrie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son William B. Jones (above)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>94.9</u> <u>Fracture femoral neck, 4-7 mos.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-7-1956</u> to <u>7-8-1956</u> , that I last saw the deceased alive on <u>July 8, 1956</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip H. Varner, M.D.</u>		ADDRESS (Street, city or town, state) <u>7702 Conn. Ave., Che. Chase, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Ind.</u>		DATE SIGNED <u>7/8/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Rose of Lima Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wenonah Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		ADDRESS <u>3821-14th. NW Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE 7-10-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07363216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3707 Stewart University</u>				d. STREET ADDRESS <u>3707 Stewart University</u>			
3. NAME OF DECEASED (Type or print) <u>Philip H. Jones</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-31-1875</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistician</u>				11. BIRTHPLACE (State or foreign country) <u>md</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Philip H. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Chaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Jos. B. Jones (son)</u> Address <u>same as dec'd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u> (c) <u>9 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C. A. of prostate</u> <u>5 yrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Boschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-20-56</u>			
EXAMINER'S NAME (Type) <u>F. J. Boschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. H. Thier Co., Washington, D.C.</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>7-21-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John B. Smith*
2. Date of Death: *July 24, 1956*
3. Place of Death: *Home*
4. Age: *65*
5. Sex: *Male*
6. Race: *White*
7. Occupation: *Retired*
8. Cause of Death: *Heart Disease*
9. Manner of Death: *Natural*
10. Signature of Examiner: *[Signature]*
11. Date of Examination: *July 24, 1956*

BUREAU V. S.

JUL 24 1956

RECEIVED

7498
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Wash. DC</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Bethesda</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>47X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Resmore Sanitarium</i>	STREET ADDRESS (If rural give location) <i>6420-14 St NW</i>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Jennie</i>	(Middle)	(Last) <i>Karshbaum</i>	(Month) <i>July</i> (Day) <i>2</i> (Year) <i>1956</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>Aug. 15, 1884</i>
9. AGE last birthday <i>71</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>	
13. FATHER'S NAME: <i>Abraham Richstein</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Litvak</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Minnie Saver - 6420-14 St N.W.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>myocardial infarction</i>			<i>2+ days</i>
ANTECEDENT CAUSE (S) (B) <i>old & recent arteriosclerotic heart disease</i>			<i>10+ yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Levix, inguinal, rt.</i>			<i>1 week</i>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/1/56</i> , 19 <i>56</i> , to <i>7/2/56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>7/1/56</i> , 19 <i>56</i> , and that death occurred at <i>2 P.</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Charles J. Savary</i>		DATE SIGNED <i>7/2/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7/3/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>		LOCATION (City, town, or county) (State) <i>Bethesda Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-5-56</i>		24. FUNERAL DIRECTOR <i>B. H. Gaudin & Sons</i> ADDRESS <i>Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 9 1956

BUREAU V. 8

CERTIFICATE OF DEATH

07365
Reg. Dist. No. 215

7499

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>3913 Blaine Street N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ellis</u> Middle <u>Curtis</u> Last <u>KENNEDY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) yrs. <u>40</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Curtis KENNEDY</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1942-1945</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Wife Mrs. Martha KENNEDY</u> <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Generalized hypoxia</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u> <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>25 June</u> , 19 <u>56</u> , to <u>2 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2 July</u> , 19 <u>56</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry A. Sohlant</u> M.D. <u>USNH, NMMC, Bethesda, Maryland</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Henry A. SOHLANT CDR MC USN</u>				<u>USNH, NMMC, Bethesda, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6 Jul 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. JARVIS</u> ADDRESS <u>1432 U Street, N.W.</u> <u>Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 3 Jul 1956</u>		24b. REGISTRAR'S SIGNATURE <u>May E. Parrelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James (Lester) Smith</i>		AGE <i>51</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>July 3, 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Md.</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		DURATION OF ILLNESS <i>2 days</i>		PREVIOUS ILLNESS <i>None</i>		PREVIOUS SURGERY <i>None</i>		PREVIOUS TRAUMA <i>None</i>		PREVIOUS DRUGS <i>None</i>		PREVIOUS ALCOHOL <i>None</i>		PREVIOUS TOBACCO <i>None</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	
DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>		DATE OF SIGNATURE <i>July 3, 1956</i>	

RECEIVED
JUL 5 1956
BUREAU V. 1

7410

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>KRAUSE</u> Last <u>KROUSE</u>				4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 July 1956</u>		9. AGE (In years last birthday) yrs. <u>50</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>50</u> Days <u>50</u> Hours <u>50</u> Min. <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Julius H. KROUSE, III</u>				14. MOTHER'S MAIDEN NAME <u>Helen SHIRLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) Julius H. KROUSE (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATURITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY</u> DUE TO (c) <u>— APPROX 22 WKS GEDATION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 July</u> , 19 <u>56</u> , to <u>26 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>26 July</u> , 19 <u>56</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Maryland</u> DATE SIGNED <u>1956</u>							
ACTUAL SIGNATURE <u>Daniel Shuptar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Maryland</u>				DATE SIGNED <u>1956</u>			
PHYSICIAN'S NAME (Type) <u>LT Daniel SHUPTAR USNR</u> <u>U.S. Naval Hospital, Bethesda, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> <u>R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave</u>				24a. REC'D BY REGISTRAR <u>DATE 7-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary L. Parrell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>		<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF DECEASED</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF DECEASED</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF DECEASED</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF DECEASED</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. F.

JUL 30 1956

RECEIVED

7331

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>35 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Of Columbia</u> <u>47X-3</u>			
d. STREET ADDRESS <u>509 Sheridan St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Labofish</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-10</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>William H. Labofish</u>				14. MOTHER'S MAIDEN NAME <u>Sue Smoot</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>MARY D LABOFISH</u> Address <u>389 SHERIDAN WIFE NW</u> <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Echymia of Marfan</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Recurrent carcinoma of L lung</u> DUE TO (c) <u>Rt. lung removed Jan 3, 1956</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Jan 3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/15/56</u> to <u>7/18/56</u> , that I last saw the deceased alive on <u>7/17/56</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. H. Wolton</u>				ADDRESS (Street, city or town, state) <u>509 Sheridan St. Wash. DC</u>		DATE SIGNED <u>7/18/56</u>	
PHYSICIAN'S NAME (Type) <u>Chas. H. Wolton</u>				M.D. <u>Wash. DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Thompson</u>				ADDRESS <u>4817 Malone St.</u>		24a. REC'D BY REGISTRAR DATE <u>7/21/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 252

7411

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>		d. STREET ADDRESS <u>214 Croydon Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary Price Kane</u>		4. DATE OF DEATH <u>July 27 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 20 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>Greenstown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Price</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Wicks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-03-0275</u>	
17. INFORMANT <u>W. M. K. Kane</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Generalized</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of Pharynx & Melastoma</u> DUE TO (c) <u>148X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1953</u> , to <u>27 July 1956</u> , that I last saw the deceased alive on <u>24 July 1956</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Ziegler</u>		DATE SIGNED <u>27 July 56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>		ADDRESS (Street, city or town, state) <u>Olney, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 30, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christenfield Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Certified Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Patton</u>		ADDRESS <u>for Barton Bros, Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>Edna Armstrong</u>		24b. REGISTRAR'S SIGNATURE <u>Edna Armstrong</u>	
DATE <u>7/28/56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. NO.

Montgomery
10 days
Rockville
4th Crofton Ave
Mrs. M. J. Price
White
Retired
Housewife
James Price
No NO
22-03-00
Virginia Works
Greenwood, Md. 2244
Nov 20 1897 28
have
July 27 25

RECEIVED
JUL 31 1956
BUREAU V. 2

8:42

CERTIFICATE OF DEATH

Reg. Dist. No. 215

7412

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Bethesda) (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 4236 S. 32nd Street	
3. NAME OF DECEASED (Type or print) First Arthur Middle Joseph Last LANG		4. DATE OF DEATH Month July Day 31 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1897
9. AGE (In years last birthday) 58 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY USMC (Retired)	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael J. LANG		14. MOTHER'S MAIDEN NAME Catherine Mahoney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I&II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Fredna W. LANG (Wife) (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) renal failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) gout and renal calculi DUE TO (c) gout INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerotic Heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 June , 1956 , to 31 July , 1956 , that I last saw the deceased alive on 31 July , 1956 , and that death occurred at 05:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC, Bethesda, Md. DATE SIGNED 7-31-56			
ACTUAL SIGNATURE Arthur J. Johnson M.D.		DATE SIGNED 7-31-56	
PHYSICIAN'S NAME (Type) Arthur J. Johnson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.J. Murphy Funeral Home, 3524 Columbia Pike		24a. REC'D BY REGISTRAR DATE 7-31-56	
24b. REGISTRAR'S SIGNATURE Mary E. Parselly			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
J. J. HOOVER		45		M		W		1910		BALTIMORE, MD	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1935		BALTIMORE, MD		J. J. HOOVER		1955		BALTIMORE, MD	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
FEDERAL BUREAU OF INVESTIGATION		1955		BALTIMORE, MD		FEDERAL BUREAU OF INVESTIGATION		1955		BALTIMORE, MD	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1955		BALTIMORE, MD		J. J. HOOVER		1955		BALTIMORE, MD	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1955		BALTIMORE, MD		J. J. HOOVER		1955		BALTIMORE, MD	
EDUCATION		DATE		PLACE		NAME OF SCHOOL		DATE OF DEATH		PLACE OF DEATH	
HIGH SCHOOL		1930		BALTIMORE, MD		J. J. HOOVER		1955		BALTIMORE, MD	
RELIGION		DATE		PLACE		NAME OF CHURCH		DATE OF DEATH		PLACE OF DEATH	
CATHOLIC		1930		BALTIMORE, MD		J. J. HOOVER		1955		BALTIMORE, MD	
SIGNED		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
J. J. HOOVER		1955		BALTIMORE, MD		J. J. HOOVER		1955		BALTIMORE, MD	

BUREAU V. 2

AUG 1 1956

RECEIVED

7413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Roseville</u>				c. LENGTH OF STAY IN 1b <u>3 yrs. 3 mo. 15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>				d. STREET ADDRESS <u>10207 South Moor Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>George</u> Last <u>Lange, Jr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov-30-1867</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instrument maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Kassel-Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Heinrich August Lange</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Ottilie John</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Oscar George Lange, Jr.</u>		Address <u>10207 South Moor Drive Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial insufficiency</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>53</u> , to <u>July 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 10th</u> , 19 <u>56</u> , and that death occurred at <u>2:45</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rockville, Maryland</u> DATE SIGNED <u>7-19-1956</u>							
ACTUAL SIGNATURE <u>Wheeler O. Huff</u>				M.D. <u>R.F.D. - not</u>			
PHYSICIAN'S NAME (Type) <u>Wheeler O. Huff M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>Laurel Kragtorp</u>	
				DATE <u>7/12/56</u>		24b. REGISTRAR'S SIGNATURE <u>per EC</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1910		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1956		10:00 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

JUL 13 1956

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07371

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <i>Maple Lane Sanitarium</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>321 Cyle Lodge</i> COUNTY <i>Washington DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring MD</i>	c. LENGTH OF STAY IN 1b <i>4 yrs 6 wks</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington DC</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maple Lane Sanitarium</i>		d. STREET ADDRESS <i>Silver Spring MD</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Elsie</i> Middle <i>Loretta</i> Last <i>Larsen</i>		4. DATE OF DEATH Month <i>July</i> Day <i>8</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 13, 1898</i>
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Religious worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Telephone Co</i>	11. BIRTHPLACE (State or foreign country) <i>Washington, DC</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Joseph J Dyer</i>	
14. MOTHER'S MAIDEN NAME <i>Thomas Day</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>577-01-1176</i>		17. INFORMANT Address <i>Maple Lane Sanitarium-Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic pneumonia</i> <i>416X</i> DUE TO <i>Pneumonia Heart Disease and</i> <i>Essential Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Brain secondary to pneumonia</i> (c) <i>Brain secondary to pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma both lungs primary</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept</i> , 19 <i>50</i> , to <i>July 8</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>July 7</i> , 19 <i>56</i> , and that death occurred at <i>1:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Courtney</i> M.D.		ADDRESS (Street, city or town, state) <i>5601-400 NW Wash DC</i>	
PHYSICIAN'S NAME (Type) <i>J. Courtney MD</i>		DATE SIGNED <i>7-13-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7/11/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Company</i> ADDRESS <i>Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>7-13-56</i>	24b. REGISTRAR'S SIGNATURE <i>Francis C. Allen</i>

CERTIFICATE OF DEATH

Page 2 of 2

1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>July 15, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		12. SIGNATURE OF DECEASED <i>John J. Smith</i>	
13. SIGNATURE OF WITNESS <i>John J. Smith</i>		14. SIGNATURE OF WITNESS <i>John J. Smith</i>		15. SIGNATURE OF WITNESS <i>John J. Smith</i>	
16. SIGNATURE OF WITNESS <i>John J. Smith</i>		17. SIGNATURE OF WITNESS <i>John J. Smith</i>		18. SIGNATURE OF WITNESS <i>John J. Smith</i>	
19. SIGNATURE OF WITNESS <i>John J. Smith</i>		20. SIGNATURE OF WITNESS <i>John J. Smith</i>		21. SIGNATURE OF WITNESS <i>John J. Smith</i>	
22. SIGNATURE OF WITNESS <i>John J. Smith</i>		23. SIGNATURE OF WITNESS <i>John J. Smith</i>		24. SIGNATURE OF WITNESS <i>John J. Smith</i>	
25. SIGNATURE OF WITNESS <i>John J. Smith</i>		26. SIGNATURE OF WITNESS <i>John J. Smith</i>		27. SIGNATURE OF WITNESS <i>John J. Smith</i>	
28. SIGNATURE OF WITNESS <i>John J. Smith</i>		29. SIGNATURE OF WITNESS <i>John J. Smith</i>		30. SIGNATURE OF WITNESS <i>John J. Smith</i>	
31. SIGNATURE OF WITNESS <i>John J. Smith</i>		32. SIGNATURE OF WITNESS <i>John J. Smith</i>		33. SIGNATURE OF WITNESS <i>John J. Smith</i>	
34. SIGNATURE OF WITNESS <i>John J. Smith</i>		35. SIGNATURE OF WITNESS <i>John J. Smith</i>		36. SIGNATURE OF WITNESS <i>John J. Smith</i>	
37. SIGNATURE OF WITNESS <i>John J. Smith</i>		38. SIGNATURE OF WITNESS <i>John J. Smith</i>		39. SIGNATURE OF WITNESS <i>John J. Smith</i>	
40. SIGNATURE OF WITNESS <i>John J. Smith</i>		41. SIGNATURE OF WITNESS <i>John J. Smith</i>		42. SIGNATURE OF WITNESS <i>John J. Smith</i>	
43. SIGNATURE OF WITNESS <i>John J. Smith</i>		44. SIGNATURE OF WITNESS <i>John J. Smith</i>		45. SIGNATURE OF WITNESS <i>John J. Smith</i>	
46. SIGNATURE OF WITNESS <i>John J. Smith</i>		47. SIGNATURE OF WITNESS <i>John J. Smith</i>		48. SIGNATURE OF WITNESS <i>John J. Smith</i>	
49. SIGNATURE OF WITNESS <i>John J. Smith</i>		50. SIGNATURE OF WITNESS <i>John J. Smith</i>		51. SIGNATURE OF WITNESS <i>John J. Smith</i>	
52. SIGNATURE OF WITNESS <i>John J. Smith</i>		53. SIGNATURE OF WITNESS <i>John J. Smith</i>		54. SIGNATURE OF WITNESS <i>John J. Smith</i>	
55. SIGNATURE OF WITNESS <i>John J. Smith</i>		56. SIGNATURE OF WITNESS <i>John J. Smith</i>		57. SIGNATURE OF WITNESS <i>John J. Smith</i>	
58. SIGNATURE OF WITNESS <i>John J. Smith</i>		59. SIGNATURE OF WITNESS <i>John J. Smith</i>		60. SIGNATURE OF WITNESS <i>John J. Smith</i>	
61. SIGNATURE OF WITNESS <i>John J. Smith</i>		62. SIGNATURE OF WITNESS <i>John J. Smith</i>		63. SIGNATURE OF WITNESS <i>John J. Smith</i>	
64. SIGNATURE OF WITNESS <i>John J. Smith</i>		65. SIGNATURE OF WITNESS <i>John J. Smith</i>		66. SIGNATURE OF WITNESS <i>John J. Smith</i>	
67. SIGNATURE OF WITNESS <i>John J. Smith</i>		68. SIGNATURE OF WITNESS <i>John J. Smith</i>		69. SIGNATURE OF WITNESS <i>John J. Smith</i>	
70. SIGNATURE OF WITNESS <i>John J. Smith</i>		71. SIGNATURE OF WITNESS <i>John J. Smith</i>		72. SIGNATURE OF WITNESS <i>John J. Smith</i>	
73. SIGNATURE OF WITNESS <i>John J. Smith</i>		74. SIGNATURE OF WITNESS <i>John J. Smith</i>		75. SIGNATURE OF WITNESS <i>John J. Smith</i>	
76. SIGNATURE OF WITNESS <i>John J. Smith</i>		77. SIGNATURE OF WITNESS <i>John J. Smith</i>		78. SIGNATURE OF WITNESS <i>John J. Smith</i>	
79. SIGNATURE OF WITNESS <i>John J. Smith</i>		80. SIGNATURE OF WITNESS <i>John J. Smith</i>		81. SIGNATURE OF WITNESS <i>John J. Smith</i>	
82. SIGNATURE OF WITNESS <i>John J. Smith</i>		83. SIGNATURE OF WITNESS <i>John J. Smith</i>		84. SIGNATURE OF WITNESS <i>John J. Smith</i>	
85. SIGNATURE OF WITNESS <i>John J. Smith</i>		86. SIGNATURE OF WITNESS <i>John J. Smith</i>		87. SIGNATURE OF WITNESS <i>John J. Smith</i>	
88. SIGNATURE OF WITNESS <i>John J. Smith</i>		89. SIGNATURE OF WITNESS <i>John J. Smith</i>		90. SIGNATURE OF WITNESS <i>John J. Smith</i>	
91. SIGNATURE OF WITNESS <i>John J. Smith</i>		92. SIGNATURE OF WITNESS <i>John J. Smith</i>		93. SIGNATURE OF WITNESS <i>John J. Smith</i>	
94. SIGNATURE OF WITNESS <i>John J. Smith</i>		95. SIGNATURE OF WITNESS <i>John J. Smith</i>		96. SIGNATURE OF WITNESS <i>John J. Smith</i>	
97. SIGNATURE OF WITNESS <i>John J. Smith</i>		98. SIGNATURE OF WITNESS <i>John J. Smith</i>		99. SIGNATURE OF WITNESS <i>John J. Smith</i>	
100. SIGNATURE OF WITNESS <i>John J. Smith</i>		101. SIGNATURE OF WITNESS <i>John J. Smith</i>		102. SIGNATURE OF WITNESS <i>John J. Smith</i>	

BUREAU Y. S.

JUL 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07372

7415

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> <u>3yr 11mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>		d. STREET ADDRESS <u>1914 Comm Ave Apt 302</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Sue Rust Lee</u>		4. DATE OF DEATH <u>July 8 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2, 1871</u>
9a. AGE (In years last birth day) <u>84</u> yrs.		9b. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Alexandria Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Rust</u>		14. MOTHER'S MAIDEN NAME <u>Mary Nelson Locke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerosis</u> DUE TO (c) <u>chronic arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/3/56</u> , 19 <u>56</u> to <u>7/8/56</u> , 19 <u>56</u> that I last saw the deceased alive on <u>7/4/56</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7/8/56</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph [Signature]</u>		ADDRESS <u>Washington Pennsylvania Ave</u>	
24a. REC'D BY REGISTRAR <u>7-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

David West -
Mary Nelson Hooker
Alexander Co. - N.S. #
W. West
Mrs. Sue West
Brooke Grove Chronic Hosp - 1111 Comm. for Patients
City of Springfield
District of Columbia

RECEIVED
JUL 18 1956
BUREAU V. 1

J. M. B. 14 -

07373

7416 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN SILVER SPRING		LENGTH OF STAY (in this place) 11 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1506 HIGHLAND DRIVE				STREET ADDRESS (If rural give location) 1506 HIGHLAND DRIVE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ROBERT (Middle) STANLEY (Last) LITSINGER				(Month) JULY (Day) 26 (Year) 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPT. 9, 1884	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER, EPISCOPAL (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM LITSINGER				14. MOTHER'S MAIDEN NAME AMERLIA HAWKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. YES		17. INFORMANT & ADDRESS Mrs. Blance W. Litsinger			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) AC. MYOCARDIAL INFARCTION				1506 Highland Drive Silver Spring, Md.		40 MIN.	
ANTECEDENT CAUSE(S) DUE TO (B) ATHEROSCLEROSIS, MODERATE, GEN.						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. SEVERE OSTEO ARTHRITIS MODERATE						UNKNOWN	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 46, to 26 JULY, 19 56, that I last saw the deceased alive on 26 JULY, 19 56, and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE L. Marshall Curllier Jr.				DATE SIGNED 27 July 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 7/28/56		NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. REC'D BY REGISTRAR DATE 7-30-56		REGISTRAR'S SIGNATURE Francesco Potter		25. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Form No. 100

U. S. DEPARTMENT OF HEALTH - BALTIMORE 15

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

BUREAU V. S.

AUG 1 1956

RECEIVED

VS. A15ME(S)
SM 9/55

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07375

Reg. Dist. No. 216

7418

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		STATE Md.		COUNTY Mont.			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westmoreland Hills		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westmoreland Hills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5231 Mass. Ave.				STREET ADDRESS (If rural give location) 5231 Mass. Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Horace		(Middle) Henry		(Last) Lybrand		(Month) (Day) (Year) 7-13-56	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 12/27/1885	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Advisor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept of Justice		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lybrand				14. MOTHER'S MAIDEN NAME Margaret Shipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Lulu M. Lybrand wife			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
162X IMMEDIATE CAUSE (A) Bronchogenic carcinoma						6 mo.	
ANTECEDENT CAUSE(S) DUE TO (B) with pleural metastasis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION April 56		19b. MAJOR FINDINGS OF OPERATION pleural carcinomatosis		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-21-56 , to 7-7-56 , that I last saw the deceased alive on 7-7-56 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
SIGNATURE C.P. Ryland		M.D. 4400-47 St. N.W.		ADDRESS (Street, city, town, state) Pr. Geo. Co., Maryland		DATE SIGNED 7-13-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 7/16/56		NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		LOCATION (City, town, or county) (State) Wash 9, D.C.	
24. REC'D BY REGISTRAR DATE 7-14-56		REGISTRAR'S SIGNATURE Russie M. Thompson		25. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W.			

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex and age

3. Date of birth

4. Place of birth

5. Date of death

6. Cause of death

7. Place of death

8. Signature of physician

9. Signature of registrar

10. Signature of informant

11. Signature of witness

12. Signature of undertaker

13. Signature of funeral home

14. Signature of cemetery

15. Signature of burial place

16. Signature of burial place

17. Signature of burial place

18. Signature of burial place

19. Signature of burial place

20. Signature of burial place

21. Signature of burial place

22. Signature of burial place

23. Signature of burial place

24. Signature of burial place

25. Signature of burial place

26. Signature of burial place

27. Signature of burial place

28. Signature of burial place

29. Signature of burial place

30. Signature of burial place

31. Signature of burial place

32. Signature of burial place

33. Signature of burial place

34. Signature of burial place

35. Signature of burial place

36. Signature of burial place

37. Signature of burial place

38. Signature of burial place

39. Signature of burial place

40. Signature of burial place

41. Signature of burial place

42. Signature of burial place

43. Signature of burial place

44. Signature of burial place

BUREAU V. 2

JUL 16 1956

RECEIVED

U.S. DEPARTMENT OF HEALTH - BATHING, 19

U.S. DEPARTMENT OF HEALTH - BATHING, 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7419

CERTIFICATE OF DEATH

Reg. Dist. No. 07376 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes Health		d. STREET ADDRESS 411 4th St. N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Virginia Middle Fern Last Lyman		4. DATE OF DEATH Month July Day 7 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 3, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Millard Owens		14. MOTHER'S MAIDEN NAME Della Meek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT The medical record		Address Nat'l Inst of Health The Clinical Center Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive cerebral hemorrhage and infarction DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of the breast, lungs & brain DUE TO months (c) Carcinoma, right breast 2 years		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29, 19 56 , to July 7, 19 56 , that I last saw the deceased alive on July 7, 19 56 , and that death occurred at 7:58 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Jude		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda, Maryland	
PHYSICIAN'S NAME (Type) James R. Jude, M.D.		DATE SIGNED 7-11-56	
22a. BURIAL, CREMATION, or REMOVAL (Specify) 7/10/56		22b. DATE THEREOF 7/10/56	
22c. NAME OF CEMETERY OR CREMATORY Nat'l Mem. Park Cem.		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Co. Washington, D.C.		24a. REC'D BY REGISTRAR 7-11-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07377
Reg. Dist. No. 216

7420

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John c. LENGTH OF STAY IN 1b Washington, D.C. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1703 Woodrow Place		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 44X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1442 Foxhall Road, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle ALEXANDER Last MAGRUDER		4. DATE OF DEATH Month July 2, Day 19 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1870
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months 3 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Capitol Transit	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas E. Magruder		14. MOTHER'S MAIDEN NAME Mary Hendley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mary L. Windsor- Item # 2	
17. INFORMANT Mary L. Windsor- Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 Cerebral Vascular Accident DUE TO (b) Hypertension DUE TO (c) Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH one year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 55 to July 2, 1956 that I last saw the deceased alive on July 2, 1956 and that death occurred at 10:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/2/56			
ACTUAL SIGNATURE Andrew E. Rudnai M.D.			
PHYSICIAN'S NAME (Type) Andrew E. Rudnai - 5120 MacArthur Blvd., N.W. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/56	
22c. NAME OF CEMETERY OR CREMATORY Herman Ch. Cem.		22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-3-56	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through.

Handwritten notes and signatures in the center of the page, including a large signature that appears to read "George C. ...".

BUREAU V. 2

JUL 6 1956

RECEIVED

7421

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 56 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church				d. STREET ADDRESS 6904 Pine Tree Terrace			
3. NAME OF DECEASED (Type or print) First Melanie Middle Leigh Last MANSON				4. DATE OF DEATH Month July Day 17 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 April 1951		9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank A. MANSON				14. MOTHER'S MAIDEN NAME Orie Lee PICKREN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Frank A. Manson (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Neuroblastoma, with generalized DUE TO (c) metastases to bone liver lung brain and kidneys. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 May , 19 56 , to 17 July , 19 56 , that I last saw the deceased alive on 17 July , 19 56 , and that death occurred at 10:40P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Cone, Jr.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNM, Bethesda, Md. DATE SIGNED 7-19-56			
PHYSICIAN'S NAME (Type) Thomas E. Cone, Jr. CAPT MC USN				U.S. Naval Hospital, NNM, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-20-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE IVES Funeral Home				ADDRESS Virginia		24a. REC'D BY REGISTRAR DATE 7-17-56	
				24b. REGISTRAR'S SIGNATURE Brady E. Russell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

• 9561 02 Jul

RECEIVED

7422
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5123 Manning Drive				d. STREET ADDRESS 5123 Manning Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First AUGUST Middle A. Last MARQUES				4. DATE OF DEATH Month July Day 3 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/12	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 10 Days 11		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Govt.				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) New York City	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Frutos Marques				14. MOTHER'S MAIDEN NAME Carman Forms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW 11		17. INFORMANT Georgia Marques-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 401.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Stenosis + Mitral Insufficiency DUE TO (c) Rheumatic Fever				INTERVAL BETWEEN ONSET AND DEATH 14 yrs. 14 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1948 , 19____, to July 3 , 19 56 , that I last saw the deceased alive on July 2 , 19 56 , and that death occurred at 4 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard E. Nunez M.D.				ADDRESS (Street, city or town, state) 2023 - R St. NW July 3			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Bernard E. Nunez				2023 R st., N.W. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR DATE 7-6-56	
				24b. REGISTRAR'S SIGNATURE Beattie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		Male		White		1928		Memphis, Tennessee		Memphis, Tennessee		United States of America	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
April 4, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America		April 4, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
FIREARM WOUND TO THE CHEST		Suicide		Attorney		High School		Methodist		Married		Single		Married	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
April 4, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America		April 4, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
April 4, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America		April 4, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America	

BUREAU V. 1

JUL 9 1968

RECEIVED

7423 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D. of C.</u>	COUNTY <u>47X-3</u> ✓
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Restmore Sanitarium and Hospital</u>		STREET ADDRESS (If rural give location) <u>2131 Florida Avenue, N.W.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ROBERT DOUTHAT MARSHALL</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>JULY 20 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE <u>MARRIED</u> WIDOWED <u>DIVORCED</u> SEPARATE	8. DATE OF BIRTH: <u>DEC. 7, 1872</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>BALTIMORE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JAEQUELIN AMBLER MARSHALL</u>		14. MOTHER'S MAIDEN NAME: <u>MARY LEWIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>JAEQUELIN MARSHALL (SON)</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Chronic pyelonephritis</u>			<u>3 mo's +</u>
ANTECEDENT CAUSE (B) <u>BENIGN PROSTATIC HYPERTROPHY</u>			<u>1 yr. +</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>MARCH, 1956</u> , to <u>JULY 20, 1956</u> , that I last saw the deceased alive on <u>JULY 19, 1956</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>H.D. Ecker</u>		ADDRESS <u>917-20th St. N.W.</u> DATE SIGNED <u>7/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7/23/1956</u>	NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u> LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-23-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR ADDRESS <u>Joseph Gruber's Sons, 1756 Pa. Ave. N.W., D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D. of C.

Washington

3331 Florida Avenue, N.W.

Nebraska
Nebraska
and Hospital

BUREAU V. 2

JUL 25 1956

RECEIVED

IVY HILL COMPANY

7/25/56

MAILING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film G200 7-16-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5615 Johnson Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.		d. STREET ADDRESS Bethesda	
3. NAME OF DECEASED (Type or print) Margaret Ross Massey		4. DATE OF DEATH July 4, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1873
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fabius H. Watson		14. MOTHER'S MAIDEN NAME Jacqueline Keith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter Lucy M. Massey		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Congestive Heart Failure - DUE TO 903.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Fracture of Right Hip		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days 11 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio Vascular Disease & Rt. Partial Infarction old			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Missed chair at home when sitting down	
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. June 23 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1932 , 19____, to date , 19____, that I last saw the deceased alive on 4 July 1956 , and that death occurred at 12:22 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Ball		ADDRESS (Street, city or town, state) Bethesda, Maryland	
PHYSICIAN'S NAME (Type) John G. Ball		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 7/5/56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Montlawn		22d. LOCATION (City, town, or county) (State) Raleigh, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-6-56	
24b. REGISTRAR'S SIGNATURE Bea M. Thompson			

RECEIVED

9561 6 700

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7426

CERTIFICATE OF DEATH

Reg. Dist. No. 216

07383

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>7000-22nd Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EARLE</u> Last <u>MCGEARY</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-06</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Senior Examiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK MORTON</u>		14. MOTHER'S MAIDEN NAME <u>Ida May JAMIESON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>7000-22nd Ave West Hyattsville, Md</u>	
17. INFORMANT <u>Jeannette Jewell - sister</u>		Address <u>7000-22nd Ave West Hyattsville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO <u>14 mo.</u> (c) <u>14 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 14</u> to <u>July 15</u> 19 <u>56</u> that I last saw the deceased alive on <u>July 14</u> 19 <u>56</u> and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. H. Richwine</u> M.D.		ADDRESS (Street, city or town, state) <u>5522 Western Ave Prince Georges County, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. H. RICHWINE</u>		DATE SIGNED <u>July 15 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/18/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 7-17-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Form fields for death certificate including: Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, Place of Death, and Registrar's Signature.

*Proper identification
to be made by 14-15*

BUREAU V. E.

JUL 19 1956

RECEIVED

*CH VICKHANE
2251 N. ...
25 April 1956*

7427

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 5908 HARWICK ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last KATHARINE AGNES McGRATH		4. DATE OF DEATH Month Year JULY 1 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1875
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ORGANIST		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CONN.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DEMNIS McGRATH		14. MOTHER'S MAIDEN NAME JULIA McGRATH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MADELINE SHEEHY		Address 5908 HARWICK RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 10 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 1956, to July 1 , 1956, that I last saw the deceased alive on June 30 , 1956, and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5016 - GEORGETOWN ROAD DATE SIGNED			
ACTUAL SIGNATURE Leo I. Donohue M.D.		DATE SIGNED 5016 - GEORGETOWN ROAD	
PHYSICIAN'S NAME (Type) LEO I DONOHUE MD		BETHESDA MD MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-4-56	22c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEM.	22d. LOCATION (City, town, or county) (State) MYSTIC, NEW LONDON, CONN.
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVOL		ADDRESS 2224 - WIS AV. D.C.	
24a. REC'D BY REGISTRAR Bessie M. Thompson		DATE JUL 9 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

For use in

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. 3

JUL 9 1956

RECEIVED

7428

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>TEXAS</u> b. COUNTY <u>HARRIS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Houston</u>	
c. LENGTH OF STAY IN 1b <u>4 days 1 hr.</u>		d. STREET ADDRESS <u>715 Key St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>FURMAN</u> Last <u>McKinney</u>		4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-84</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>	11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN H. MCKINNEY</u>	
14. MOTHER'S MAIDEN NAME <u>SALLIE BURDEN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>MAX McKinney - Son</u> Address <u>13208 Maycroft Wheaton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Toxemia</u> 541.1 DUE TO <u>Perforated duodenal ulcer with 5 x 1 cm. Peritonitis 4 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis, Exudative</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>56</u> , to <u>7/17</u> , 19 <u>56</u> that I last saw the deceased alive on <u>7/17</u> , 19 <u>56</u> , and that death occurred at <u>11:38 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>801 A St, N.W. Wash D.C.</u>	
ACTUAL SIGNATURE <u>Frederick Y. Donn</u> M.D.		DATE SIGNED <u>7-19-56</u>	
PHYSICIAN'S NAME (Type) <u>Frederick Y. Donn</u>			
22a. BURIAL, CREMATION, TRANS. & BURIAL <u>7/21/56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>COLEMAN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>COLEMAN, COLEMAN COUNTY, TEXAS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE - 19-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 23 1956

RECEIVED
MAY 23 1956

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurriness.

RECEIVED
JUL 30 1956
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07387
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10004 Frederick Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>10004 Frederick Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Loraine Madonia McQuinn</u> First Middle Last		4. DATE OF DEATH <u>July 23 1956</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12-29-1874</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) <u>81</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u> 11. BIRTH PLACE (State or foreign country) <u>Iowa</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Byron M. McQuinn</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Jensen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <u>Albion McQuinn</u> Address <u>10004 Frederick Ave Kensington Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (b) <input type="checkbox"/> (c), stating the underlying cause lost. DUE TO <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-28-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 7-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *James J. [illegible]*
 2. Sex: *Male*
 3. Age: *38*
 4. Date of Birth: *1918*
 5. Place of Birth: *[illegible]*
 6. Usual Residence: *[illegible]*
 7. Date of Death: *1956*
 8. Time of Death: *[illegible]*
 9. Place of Death: *[illegible]*
 10. Cause of Death: *[illegible]*
 11. Manner of Death: *[illegible]*
 12. Signature of Medical Examiner: *[illegible]*
 13. Signature of Coroner: *[illegible]*
 14. Signature of Registrar: *[illegible]*

BUREAU V. 3

JUL 31 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7430

CERTIFICATE OF DEATH

Reg. Dist. No. 216

07388

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 6 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 10402 Amherst Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle David Last McRorie				4. DATE OF DEATH Month July Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 15, 1891	
9. AGE (In years lost birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit Manager				10b. KIND OF BUSINESS OR INDUSTRY Credit Union			
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John S. McRorie				14. MOTHER'S MAIDEN NAME Sarah Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW #1				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastro intestinal hemorrhage 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Duodenal ulcer DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 30, 1956 , to July 6, 1956 , that I last saw the deceased alive on July 6, 1956 , and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED July 6, 1956 ACTUAL SIGNATURE Leonard Laster M.D. National Institutes of Health Bethesda 14, Maryland PHYSICIAN'S NAME (Type) Leonard Laster, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1956		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Forest Glen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edwener C. Pumphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR 7-10-56	
24b. REGISTRAR'S SIGNATURE Bennie M. Thompson							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
Silver Spring		Male		25		1931	
Place of Birth		Country		Race		Religion	
United States of America		United States		White		Roman Catholic	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death	
Heart Disease		Coronary Atherosclerosis		Myocardial Infarction		Natural	
Date of Death		Time of Death		Place of Death		Physician's Signature	
July 13, 1956		10:15 AM		Silver Spring, Md.		[Signature]	
Burial Place		Burial Date		Burial Time		Burial Place	
St. Mary's Cemetery		July 15, 1956		10:00 AM		St. Mary's Cemetery	
Name of Undertaker		Address of Undertaker		City of Undertaker		State of Undertaker	
[Name]		[Address]		[City]		[State]	

RECEIVED
JUL 13 1956
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07389

7431

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>102 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>3700 Massachusetts Ave., N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Evelyn</u> Last <u>Metz</u>			4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1908</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>David Daniel</u>			14. MOTHER'S MAIDEN NAME <u>Eva Jones</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse metastatic carcinoma</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anaplastic carcinoma of left breast</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4+ months</u> <u>3 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nodular non-toxic goiter</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 20, 1956</u> , to <u>July 31, 1956</u> , that I last saw the deceased alive on <u>July 31, 1956</u> , and that death occurred at <u>8:45 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Charache</u> M.D.			ADDRESS (Street, city or town, state) <u>The Clinical Center</u>			DATE SIGNED <u>7/31/56</u>	
PHYSICIAN'S NAME (Type) <u>Samuel Charache, M.D.</u>			National Institutes of Health <u>Bethesda 14, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>8-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cemetery Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Clemson</u> <u>So. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-2-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		SUICIDE		SHOOTING		MEMPHIS, TENNESSEE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		TIME OF DEATH	
APRIL 4 1968		4:00 PM		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4 1968		4:00 PM	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF FORENSIC EXAMINER		NAME OF MEDICAL EXAMINER		NAME OF NURSE		NAME OF ASSISTANT		NAME OF ATTENDING PHYSICIAN	
DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF PATHOLOGIST		SIGNATURE OF FORENSIC EXAMINER		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF NURSE		SIGNATURE OF ASSISTANT		SIGNATURE OF ATTENDING PHYSICIAN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE		COUNTRY		DATE		TIME	
APRIL 5 1968		10:00 AM		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 5 1968		10:00 AM	

RECEIVED

AUG 5 1956

BUREAU A. S.

7432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY 83x.3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural	c. LENGTH OF STAY IN lb 20 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stanton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 1505 North Augusta Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Anna First Viola Middle MIDYETT Last (AKA) MIDYETTE		4. DATE OF DEATH Month July Day 2 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Widowed		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 80 yrs.
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Leonard ROBY		14. MOTHER'S MAIDEN NAME Mary Ellen SKELTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mr. Irvin K. ROBY (Brother) Address Same as Item #2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Stomach 151 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 June , 19 56 , to 2 July , 19 56 , that I last saw the deceased alive on 2 July , 19 56 , and that death occurred at 10:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH, NNMC, Bethesda, Maryland DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. USNH, NNMC, Bethesda, Maryland PHYSICIAN'S NAME (Type) R. J. MC CARTHY CDR MC USN USNH, NNMC, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6 Jul 1956	22c. NAME OF CEMETERY OR CREMATORY National Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hoffman Funeral Home, 3218 Hudson Street, Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE 3 Jul 1956	24b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07391

CERTIFICATE OF DEATH

Reg. Dist. No. 216

7433

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>4713 S. Chelsea La.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Belle</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Richard Prossitt</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hiptrap</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miriam Roberts</u> Address <u>4604 Windsor La. Bethesda</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 19, 1956</u> to <u>July 9, 1956</u> , that I last saw the deceased alive on <u>July 9, 1956</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Coale</u>		ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave., Bethesda Md</u> DATE SIGNED <u>7/9/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert N. Coale</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-12-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>7-11/56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

87392

7434

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY 77X-3 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 83 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Steven Middle Wade Last Mills				4. DATE OF DEATH Month July Day 9 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 24, 1953	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. DATE OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas V. Mills				14. MOTHER'S MAIDEN NAME Maxine M. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 DUE TO Pulmonary infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO 1 yr. (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 17, 1956 , to July 9, 1956 , that I last saw the deceased alive on July 9, 1956 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Claude E. Forkner, Jr. M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/9/56			
PHYSICIAN'S NAME (Type) Claude E. Forkner, Jr.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans. 7-10-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Hamilton Cem.		22d. LOCATION (City, town, or county) (State) Marion Co. Ala.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR 7-10-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7435

CERTIFICATE OF DEATH

Reg. Dist. No. 215

07393

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1956</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negroid</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. NAME OF DECEASED (Type or print) First <u>Lila</u> Middle <u>(n)</u> Last <u>MIMS</u>		9. AGE (In years last birthday) <u>58 yrs</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. <u>Appears older</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>(Unknown) Glover</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Son Travis MIMS CS2 USN</u> <u>Same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Subarachnoid</u> <u>330x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 June</u> , 19 <u>56</u> , to <u>2 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2 July</u> , 19 <u>56</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>C. Mc Carthy</u> M.D. <u>USNH, NMMC, Bethesda, Maryland</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>R. J. MC CARTHY CDR MC USN</u>		ADDRESS <u>USNH, NMMC, Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Transit</u>		22b. DATE THEREOF <u>6 Jul 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fraziers Funeral Home, 389 Rhode Island Avenue NW, Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 3 Jul 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Carvelly</u>			

NAVY AND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

BUREAU V. J.

JUL 5 1956

RECEIVED

7333

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>41X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San + Hosp</u>				d. STREET ADDRESS <u>425 Decatur St. NW</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>—</u> Last <u>Mindel</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 25 - ? 1915</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>u.s.a.</u>							
13. FATHER'S NAME <u>unknown to Pt.</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Zendel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>wash. San + Hosp Records + Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>194X congestive heart failure - (cardiopulmonary)</u> DUE TO (b) <u>Pulmonary Insufficiency</u> DUE TO (c) <u>Thyroid Carcinoma & Pleural Metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 months</u> <u>11 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>13 July</u> , 19 <u>56</u> , to <u>26 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>26 July</u> , 19 <u>56</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack Crowell</u>				ADDRESS (Street, city or town, state) <u>2025 EYE ST, N.W Washington DC</u>			
DATE SIGNED <u>26 July '56</u>							
PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELES AVET GRAD CM</u>		22d. LOCATION (City, town, or county) (State) <u>DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edberg & Son</u>				ADDRESS <u>4217-98th St. SE</u>		24a. REC'D BY REGISTRAR <u>J. H. H. Noddy</u>	
DATE <u>7/18/56</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG200 7-24-56 et

CERTIFICATE OF DEATH

07396

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>FAIRFAX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12201 Rockville Pike</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McLean</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL SANITARIUM</u>		d. STREET ADDRESS <u>R.F.D.#1, BOX 133</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Mohon</u> Last <u>Mohon</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>7</u> Hours <u>1</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>file clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Cal. Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANCIS J Mohon</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Roever</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>R.F.D.#1 BX-133</u>	
17. INFORMANT <u>James H. Mohon (son)</u>		Address <u>McLean, VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>3 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Vesico-colic fistula</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1956</u> to <u>July 12, 1956</u> ; that I last saw the deceased alive on <u>July 11, 1956</u> , and that death occurred at <u>7:55 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Havell</u>		M.D. <u>5516 Nebraska Ave</u> DATE SIGNED <u>7/12/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>		<u>Washington DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/12/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARI. Vn.</u>		22d. LOCATION (City, town, or county) (State) <u>McLean Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. M. Turner</u>		ADDRESS <u>2847 Wilson Blvd.</u>	
24a. REC'D BY REGISTRAR DATE <u>7/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>Laurell Fragtorp</u>	

per EC

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

DATE OF DEATH

HABIT

PLACE OF DEATH

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 2

JUL 17 1956

RECEIVED

116.05

MARYLAND STATE DEPARTMENT OF HEALTH

67397

2411 N. Charles Street, Baltimore

7437

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN KENSINGTON		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Eddington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3001 FERNDAL STREET		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) BRIDGET (Middle) MARY (Last) MONAHAN		4. DATE OF DEATH (Month) JULY (Day) 23, (Year) 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Aug. 1875
9. AGE last birthday 80 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HOWARD		14. MOTHER'S MAIDEN NAME MARY LYNN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT AND ADDRESS MRS. MARY F. BOONE, 3001 Ferndale St.			

18. MEDICAL CERTIFICATION Kensington, Maryland		INTERVAL BETWEEN ONSET AND DEATH 3 days
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Bronchopneumonia		
Antecedent cause(s) (b) Arterio-sclerotic Heart Disease with Congestive Failure, 10 years		
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Generalized Arterio-sclerosis, 10 years		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 5, 1956, to July 23, 1956, that I last saw the deceased alive on July 23, 1956, and that death occurred at 6:50 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL, Specimen Trans. & Burial	DATE THEREOF 7/27/56	NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery	LOCATION (City, town, or county) (State) Bristol, Bucks County, Pa.
DATE REC'D BY LOCAL REG. 7-24-56	REGISTRAR'S SIGNATURE Frances Potter	24. FUNERAL DIRECTOR Warner & Humphrey	ADDRESS Silver Spring, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 27 1956
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7334

CERTIFICATE OF DEATH

87398
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash 199 for Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harriette</u> Middle <u>Chapin</u> Last <u>Montague</u>				4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>12</u> Day <u>10</u> Year <u>1920</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edmund Montague</u>				14. MOTHER'S MAIDEN NAME <u>Sarah C. Horton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Alex., Va.</u> <u>C. F. Montague, Hollin Hall Village, 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aortic aneurysm</u> DUE TO (b) <u>arterio sclerosis of aorta</u> DUE TO (c) <u>Torsion of gall bladder</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>intestinal obstruction</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 8</u> , 19 <u>56</u> , to <u>July 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>56</u> , and that death occurred at <u>9:50 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Takoma Park Md</u> DATE SIGNED <u>7/15/56</u> ACTUAL SIGNATURE <u>J. M. Whitelock</u> M.D. <u>J. M. Whitelock</u> PHYSICIAN'S NAME (Type) <u>J. M. Whitelock</u> <u>Takoma, Park, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/18/56</u>		<u>Rock Creek Cem.</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulus Sons</u> ADDRESS <u>1756 Ave. N.W.</u>				24. REC'D BY REGISTRAR <u>Jul 18 1956</u> REGISTRAR'S SIGNATURE <u>J. Wilson</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
O. T. Montague, Hollis Hall Village, Alaska, U.S.A.		Male		35		1920		Hollis Hall Village, Alaska, U.S.A.	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
DATE OF MARRIAGE		DATE OF DIVORCE		DATE OF WIDOWED		DATE OF DEATH		PLACE OF DEATH	
						1955		Hollis Hall Village, Alaska, U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath		Medical Attention	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
1955		10:00 AM		Hollis Hall Village, Alaska, U.S.A.		1955		Hollis Hall Village, Alaska, U.S.A.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER OF RELIGION		SIGNATURE OF CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

USA

O. T. Montague, Hollis Hall Village, Alaska, U.S.A.

BUREAU V. 2

JUL 18 1955

RECEIVED

Tokoma, P.

J. N. Whitehook

Book Creek Co.

Alaska

Final

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67399

7438

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>Route I</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leonard Robert Moore</u>		4. DATE OF DEATH Month Day Year <u>July 16 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Equipment Operator State Roads</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. Co. Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Moore</u>		14. MOTHER'S MAIDEN NAME <u>Margaretta Sidney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>587.0</u>	
17. INFORMANT <u>Wife Sarah Moore - above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>587.0</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/9/56</u> , 19 <u>56</u> , to <u>7/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>56</u> , and that death occurred at <u>3:45</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alvin I. Kay MD</u>		ADDRESS (Street, city or town, state) <u>1835 Eye St NW - Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>ALVIN I. KAY MD</u>		DATE SIGNED <u>7/16/56</u>	
22a. BURIAL, CREMATION, REBURYAL (Specify) <u>REBURYAL</u>		22b. DATE TIME OF <u>7/19/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>Cloppers, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowden</u>		24a. REC'D BY REGISTRAR <u>20-56</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. 5

9561 24 JAN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G200, 7/27/56 bh **CERTIFICATE OF DEATH**

Reg. Dist. No. **07400 216**

1. PLACE OF DEATH a. COUNTY Montgomery 7439 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. 40 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 3 Parkhill Rd, apt. 413 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Teresa Middle M Last Mulinari		4. DATE OF DEATH Month July Day 18 Year 1956	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1897
9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (State or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph De Fontes		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. - 17. INFORMANT E. Joseph Mulinari Address 30 Parkhill Rd, apt. 413, Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia DUE TO 332 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 6 hrs 12 hrs Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1956 , to 7/18, 1956 , that I lost saw the deceased alive on 7/18, 1956 , and that death occurred at 4:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen J. Jones		ADDRESS (Street, city or town, state) Rockville Md DATE SIGNED 7/18/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/20/1956	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armagost		24. REC'D BY REGISTRAR DATE 23 1956	
ADDRESS 4600 Liberty Hghts. Ave		24b. REGISTRAR'S SIGNATURE Lessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 3 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

87401

7440

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cathedral City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>3427 N. Malt St. N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>Jane</i> Last <i>Murray</i>		4. DATE OF DEATH Month <i>July</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 1st 1892</i>
9. AGE (If years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR Months <i>2</i> Days <i>4</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Isaac Idite</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Hander</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. Gladys Tahoney</i>		Address <i>332 W. College St. Frederick, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420.0 DUE TO <i>Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO <i>Heart failure</i> (c) <i>4 yrs.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X mild Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 12, 1956</i> to <i>July 14, 1956</i> ; that I last saw the deceased alive on <i>July 13, 1956</i> , and that death occurred at <i>1:35 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. H. Richwine</i>		ADDRESS (Street, city or town, state) <i>5522 Western Ave. N.W. Washington, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>A. H. RICHWINE</i>		DATE SIGNED <i>July 15, 1956</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7/16/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Company</i>		ADDRESS <i>Washington, D.C.</i>	
24a. REC'D BY REGISTRAR <i>DATE 16-56</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

11/1/55

1895

1955

Grassroots Development

11 2

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

1000

155555

[Faint handwritten notes at the bottom of the page]

21/10/19

100

25 1872

CONFIDENTIAL

Handwritten signature: *Handwritten signature*

1. The first of these is the fact that the
 2. second of these is the fact that the
 3. third of these is the fact that the
 4. fourth of these is the fact that the
 5. fifth of these is the fact that the
 6. sixth of these is the fact that the
 7. seventh of these is the fact that the
 8. eighth of these is the fact that the
 9. ninth of these is the fact that the
 10. tenth of these is the fact that the

JUL 18 1956
 BUREAU V. 3

RECEIVED

9561 81 6700

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7441

CERTIFICATE OF DEATH

07402
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Res.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u> d. STREET ADDRESS <u>3414 40th Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>(none)</u> Last <u>NAGAO</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1956</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Japanese</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>				11. BIRTHPLACE (State or foreign country) <u>Japan</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> Unknown <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT Address <u>Hyattsville, Md.</u> <u>(Son) Albert H. NAGAO, 4412 Underwood St.,</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal hemorrhage</u> DUE TO <u>451X</u> (b) <u>chronic renal disease with uraemia</u> DUE TO <u>generalized atherosclerosis and abdominal aneurysm</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>2 months</u> <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from <u>7 June</u> , 19 <u>56</u> , to <u>6 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 July</u> , 19 <u>56</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>7-7-56</u> ACTUAL SIGNATURE <u>Harold I. Passes</u> M.D.															
PHYSICIAN'S NAME (Type) <u>Harold I. PASSES, LT.MC, USNR</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10 July 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bethesda, Md.</u> 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.</u> DATE <u>7-7-56</u> <u>Frank C. Parselley</u>															

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
Item 2, See: Birth Cert. et
Item 317MB
CERTIFICATE OF DEATH

07329
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		d. STREET ADDRESS RFD # 2, Box 2	
3. NAME OF DECEASED (Type or print) WILLIAM First FRANKLIN Middle NAYLOR Last LAWRENCE PRESTON DORSEY		4. DATE OF DEATH JULY 19 1956	
5. SEX M	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 19, 1956
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 10 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE NAYLOR		14. MOTHER'S MAIDEN NAME DORSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT DELLA DORSEY - DICKERSON, MD.		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Asphyxia DUE TO 761.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prolonged dry labor and DUE TO Pressure on cord (c) —		INTERVAL BETWEEN ONSET AND DEATH 10 hours 30 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/19 1956 , to 7/19 1956 , that I last saw the deceased alive on 7/19 1956 , and that death occurred at 4:23 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 2412 Colston Dr, Silver Spring, Md. DATE SIGNED 7/19/56	
ACTUAL SIGNATURE Maynard I Cohen M.D.		PHYSICIAN'S NAME (Type) MAYNARD I COHEN Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/56	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Alexander ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 8-2-56 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

1956 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7443 CERTIFICATE OF DEATH

Reg. Dist. No. **07403**

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Tennessee b. COUNTY KNOX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION National Institutes of Health				d. STREET ADDRESS 3217 Selma Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Lee Newman		First Middle Last		4. DATE OF DEATH July 12, 1956		Day Month Year	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 February 1955		9. AGE (In years last birthday) 16 mos.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer J. Newman				14. MOTHER'S MAIDEN NAME Lillia Mellon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record, Clinical Center			
				National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure at time of surgical procedure 754.4 DUE TO to correct atrial septal defect Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atrial septal defect (c) atrial septal defect							INTERVAL BETWEEN ONSET AND DEATH Birth → 16 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 July , 1956, to 12 July , 1956, that I last saw the deceased alive on 12 July , 1956, and that death occurred at 4.00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Robinson Baker				ADDRESS (Street, city or town, state) DATE SIGNED 120 Center Drive - Bethesda - 14			
PHYSICIAN'S NAME (Type) R. Robinson Baker, M.D.				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Knoxville Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 1400 - Chapin St. N.W.		24a. REC'D BY REGISTRAR DATE JUL 16 1956	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		MD.		U.S.A.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 15 1910		BALTIMORE		MD.		U.S.A.		JUL 10 1956		BALTIMORE		MD.	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF INTERMENT		PLACE OF INTERMENT	
HEART DISEASE		NATURAL		JUL 10 1956		BALTIMORE		MD.		U.S.A.		JUL 10 1956		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		JUL 10 1956		BALTIMORE		MD.		U.S.A.		JUL 10 1956		BALTIMORE		MD.	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		JUL 10 1956		BALTIMORE		MD.		U.S.A.		JUL 10 1956		BALTIMORE		MD.	

BUREAU V. S.

JUL 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07404

7444

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville				c. LENGTH OF STAY IN 1b 4 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville			
3. NAME OF DECEASED (Type or print) Maggie First L. Middle OFFUTT Last				4. DATE OF DEATH Month July Day 3 Year 19 56			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec, 6 1912	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Louisiana	
12. CITIZEN OF WHAT COUNTRY? U.S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Daisy Gladley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Thomas E. Offutt		Address Barnesville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of cervix DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 9 Dec , 19 55 , to 3 July , 19 56 , that I last saw the deceased alive on 3 July , 19 56 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John G. Fawcett				ADDRESS (Street, city or town, state) Barnesville, Md.			
DATE SIGNED 3 July 56				M.D. MARYLAND			
PHYSICIAN'S NAME (Type) JOHN G. FAWCETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6. 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE 7/6/56	
				24b. REGISTRAR'S SIGNATURE Charles W. Elgin			

0179

of 1993

No. 290

06-01197

9 1956

RECEIVED

7445
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON GARDENS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANITARIUM</u>				d. STREET ADDRESS <u>302 Jackson Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>OLDS</u> Last <u>OLDS</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1907</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary—John Hopkins Applied Physics</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Emmott</u>				14. MOTHER'S MAIDEN NAME <u>Meq Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>090-14-4009</u>		17. INFORMANT Address <u>Alan D. Galletly, 916 Thayer Ave., Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Debilitation</u> <u>345x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart Failure</u> DUE TO (c) <u>Multiple Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 2</u> , 19 <u>56</u> , to <u>July 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>56</u> , and that death occurred at <u>2:30p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D.				ADDRESS (Street, city or town, state) <u>10609 Concord St.</u>		DATE SIGNED <u>7-27-56</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>				<u>Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>July 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Manseth, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/24/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John D. [illegible]</i>		2. SEX <i>Male</i>		3. AGE <i>35</i>	
4. DATE OF DEATH <i>July 27, 1956</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU A

JUL 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67406

7345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	c. LENGTH OF STAY IN 1b 25 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 216 Frederick Ave.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Rev. Ernest First Middle Last		4. DATE OF DEATH July 11, 19 56 Month Day Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1881 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Baptist Church	11. BIRTHPLACE (State of foreign country) Maryland. 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Harrison Palmer		14. MOTHER'S MAIDEN NAME Henrietta Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Ellen N. Palmer Address 216 Frederick, Ave., Rockville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Hypertensive Cardiorenal Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia 1954 INTERVAL BETWEEN ONSET AND DEATH July 5, 5			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 23, 1949 to July 11, 1956 , that I last saw the deceased alive on July 11, 1956 , and that death occurred at 7:34 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring, Md. DATE SIGNED ACTUAL SIGNATURE Webster Sewell M.D. PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 16, 1956	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert Snowden ADDRESS Rockville, Maryland		24a. REC'D BY REGISTRAR DATE 7/12/56	24b. REGISTRAR'S SIGNATURE Samuel King per E.C.

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Death [Illegible]	
Place of Birth [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Occupation [Illegible]		Cause of Death [Illegible]	
Medical History [Illegible]		Burial Place [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Report [Illegible]		Office of Registrar [Illegible]	

BUREAU V. 2

JUL 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7446

CERTIFICATE OF DEATH

07407
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Nebraska</u> b. COUNTY <u>64X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Omaha</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5109 PAATT ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>OTTO</u> Middle <u>HERMANN</u> Last <u>PEHLE</u>				4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-21-81</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERY</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Naturalized</u>							
13. FATHER'S NAME <u>Frederick Pehle</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>yes</u>		17. INFORMANT <u>John W. Pehle - Son</u> Address <u>15205 Chatham Drive Bethesda, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Abscesses (Multiple)</u> DUE TO <u>Broncho-Pneumonia</u> DUE TO <u>Status - Post-Prostatectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u> <u>7 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 19, 1956</u> to <u>July 5, 1956</u> , that I last saw the deceased alive on <u>July 5, 1956</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merrill M. Cross</u>				ADDRESS (Street, city or town, state) <u>8248 Silver Spring Ave</u>			
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>				DATE SIGNED <u>7/5/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>				22b. DATE THEREOF <u>7/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest lawn</u>	
22d. LOCATION (City, town, or county) <u>Omaha, Nebraska</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>7-10-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

BUREAU V. S.

701 31 5557

RECEIVED

674084

7447

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY MONTGOMERY

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN SILVER SPRING

LENGTH OF STAY (in this place) 5 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 12,612 Denley Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND

COUNTY MONTGOMERY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING 56

STREET ADDRESS (If rural give location) 12,612 Denley Road 1

3. NAME OF DECEASED:

(First)

OTHNIEL

(Middle)

ALSO

(Last)

PENDLETON

4. DATE OF DEATH:

(Month)

JULY

(Day)

27

(Year)

19 56

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH:

Jan. 20, 1877

9. AGE last birthday:

79 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): GROCERY BUSINESS * OWN BUSINESS

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

LAWRENCE B. PENDLETON

14. MOTHER'S MAIDEN NAME:

MARGARET ALSO

15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY No.:

577-36-2392

17. INFORMANT & ADDRESS:

Mrs. Edith P. Williams, 12,612 Denley Rd.

18. MEDICAL CERTIFICATION

Silver Spring, Md.

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

Immediate cause

(a)

DUE TO

Congestive heart failure

Interval Between Onset And Death

8 hrs

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

Metastatic carcinoma

(c)

Carcinoma of colon

2 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

Aug. 1954

19b. MAJOR FINDINGS OF OPERATION

Carcinoma colon

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify) None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1956, to July 27, 1957, that I last saw the deceased

alive on 7/27, 1956, and that death occurred at 240 PM

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

DATE THEREOF

7/30/56

NAME OF CEMETERY OR CREMATORY

CEDAR HILL CEMETERY

LOCATION (City, town, or county) (State)

SUITLAND, MARYLAND

DATE REC'D BY LOCAL REGISTRAR

7-30-56

REGISTRAR'S SIGNATURE

Francis Potter

24. FUNERAL DIRECTOR

Warner E. Humphrey

ADDRESS

SILVER SPRING, MD.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1956

BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7448 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07499

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GA. AVE. & WINDHAM LANE</u>				d. STREET ADDRESS <u>12,506 ROSEBUD DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>MICHAEL</u> Last <u>PEREZ</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/29</u>		9. AGE (In years last birthday) <u>26</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>SPAIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD PEREZ</u>				14. MOTHER'S MAIDEN NAME <u>SARAH A. BARNETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT Address <u>MRS. CHARLINE A. PEREZ, 12,506 Rosebud Drive Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart block</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Mitral and aortic rheumatic endocarditis</u> (c) <u>Myocardial fibrosis rt. and left ventricle</u> DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL, or SPECIFIC TRANS. & BURIAL <u>8/3/56</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>MANSFIELD, OHIO</u>		22e. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>7/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Francis P. [Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1870		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HIGH SCHOOL		MARRIED		NONE		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
AUG 3 1956		HOME		10:00 AM		100.0		80		20	
SIGNATURE OF EXAMINER		TITLE		DATE		TIME		PLACE		REMARKS	
J. H. HARRIS		M.D.		AUG 3 1956		10:00 AM		HOME		HEART DISEASE	

BUREAU V. 2

AUG 3 1956

RECEIVED

THE STATE DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 187410
7449 **CERTIFICATE OF DEATH**

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist of Columbia</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u> d. STREET ADDRESS <u>1419 Decatur St. NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rebecca</u> First <u>Martha</u> Middle <u>Pigg</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1956</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>23 May 1876</u> 9. AGE (In years last birthday) <u>80</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
13. FATHER'S NAME <u>Thomas Mebane</u>		14. MOTHER'S MAIDEN NAME <u>Rachel F. Hurdle</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Frances V. Emmons - 4450 Alton Rd. N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial occlusion - left femoral Artery</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis - generalized</u> years DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular fibrillation</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>Nov. 1955</u> , to <u>July 17, 1956</u> , that I last saw the deceased alive on <u>July 17, 1956</u> , and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4701 - Mass Ave N.W. Wash. D.C.</u> DATE SIGNED <u>7-17-56</u> ACTUAL SIGNATURE <u>Russell M. Tilley, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>Russell M. Tilley, Jr.</u> <u>Wash. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</u>					
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07411

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 7450 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seneca Creek & Wightman Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard</u> <u>Plummer Jr.</u>		4. DATE OF DEATH Month Day Year <u>7/21/56</u> <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>5/16/35</u>	9. AGE (In years last birthday) <u>21</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Plummer Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Maud Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) [Yes, no, or unknown]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Maud Jackson (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia by drowning</u> <u>934.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Swept in stream by flood waters (in auto)</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year <u>12:01</u> <u>7/21/56</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Seneca Creek</u>		20f. (City or town) (County) (State) <u>Gaithersburg</u> <u>Montg.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/25/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury,</u>		22d. LOCATION (City, town, or county) (State) <u>Germantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>July 25 - 56</u>		24b. REGISTRAR'S SIGNATURE <u>Abundant L. Cook</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. R.

JUL 30 1956

RECEIVED

7451 CERTIFICATE OF DEATH

Reg. Dist. No. 07412/4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Ind</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>2512 Forest Glen Rd.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<i>GEORGE W. POTTER</i>		<i>JULY 10 1956</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Mar 29, 1885</i>
9. AGE last birthday: <i>71</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if partly): <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Gen. Employee</i>	11. BIRTHPLACE (State or foreign country): <i>Miss.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME: <i>Jefferson Potter</i>	
14. MOTHER'S MAIDEN NAME: <i>Annie Spencer</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <i>Annie D Potter 2512 Forest Glen Rd.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cardiac failure</i>			<i>5 min</i>
ANTECEDENT CAUSE (S) <i>Complete heart block</i>			<i>3 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>Arterio sclerotic heart d.</i>			<i>10 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>August</i> , 1954, to <i>July</i> , 1956, that I last saw the deceased alive on <i>July 3</i> , 1956, and that death occurred at <i>5:45</i> AM, from the causes and on the date stated above.			
SIGNATURE <i>Samuel Coleman</i>		DATE SIGNED <i>7/10/56</i>	
ADDRESS <i>M.D. 113 Carroll St NW Wash D.C.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7.13.56</i>	
NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		LOCATION (City, town, or county) (State) <i>Switzland Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-13-56</i>		REGISTRAR'S SIGNATURE <i>Francis Potter</i>	
FUNERAL DIRECTOR <i>Deap Funeral Home</i>		ADDRESS <i>4812 E. Ave N.W.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the upper and middle portions of the page.]

BUREAU V. S.

JUL 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07413

7335

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>		d. STREET ADDRESS <i>124 Lynnmoor Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>FRANK</i> Middle <i>Baker</i> Last <i>Proctor</i>		4. DATE OF DEATH Month <i>7</i> Day <i>30</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-22-93</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Architect & Attorney-at-law</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alexander MacPherson Proctor</i>		14. MOTHER'S MAIDEN NAME <i>Annie Elizabeth Ashford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give year or dates of service) <i>WWI Army</i>		16. SOCIAL SECURITY NO. <i>217-36-8031</i>	
17. INFORMANT <i>Son - Washington San & Hosp Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion (recurrent)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>July 30, 1956</i> to <i>July 30, 1956</i> that I last saw the deceased alive on <i>July 30, 1956</i> , and that death occurred at <i>7:40 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John N. Andrews</i>		ADDRESS (Street, city or town, state) <i>964 Coleville Rd Silver Spring Md</i>	
PHYSICIAN'S NAME (Type) <i>John N. Andrews</i>		DATE SIGNED <i>July 30-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8/1/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON, VIRGINIA</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>		24. REG'D REGISTRAR'S SIGNATURE <i>J. Wilson Dadd</i>	
ADDRESS <i>8434 Georgia Ave Silver Spring Md</i>		DATE <i>JUL 31 1956</i>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>		<p>11. TIME OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>		<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF CLERK</p>	

BUREAU V. S.

AUG 1 1956

RECEIVED

10000

7452 CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL or nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and nearest town)	
TOWN <u>Silver Spring</u>	<u>1 1/2 yrs.</u>	TOWN <u>Rt. D#1 Silver Spring, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 - Bonifant Rd.</u>		STREET ADDRESS (If rural give location) <u>50 - Bonifant Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mary Frances Proctor</u>		OF DEATH: <u>July 22 1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>Oct 26, 1868</u>
		9. AGE last birthday: <u>87</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	11. BIRTHPLACE (State or foreign country): <u>Leesburg, Va.</u>
13. FATHER'S NAME: <u>William G. Bopp</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Ann Burke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
		17. INFORMANT & ADDRESS: <u>William H. Proctor - 50 Bonifant Rd.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Uremia</u>			<u>2 months</u>
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			<u>estimate 10 yrs.</u>
(B) <u>Nephrosclerosis</u>			
(C) <u>Arteriosclerosis</u>			<u>" 10-15 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>-</u>		19B. MAJOR FINDINGS OF OPERATION <u>-</u>	
		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) (M.)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I hereby certify that I attended the deceased from <u>June</u> , 1955, to <u>July 22</u> , 1956, that I last saw the deceased alive on <u>July 22, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ralph P. Patten</u>		DATE SIGNED <u>July 22, 56</u>	
		M. D. <u>8641 - Cobble Rd</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/24/56</u>	
		NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	
		LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/24/56</u>		REGISTRAR'S SIGNATURE <u>James H. Patten</u>	
		24. FUNERAL DIRECTOR <u>Warren E. Humphrey</u>	
		ADDRESS <u>Silver Spring, Md.</u>	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 150-735 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07415

7453 **CERTIFICATE OF DEATH**

Reg. Dist. No. 214

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY MONTGOMERY	MARYLAND	STATE MARYLAND	COUNTY MONTGOMERY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN SILVER SPRING	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9107 2nd AVENUE		STREET ADDRESS 9107 2nd AVENUE (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
(First) THADDEUS (Middle) E (Last) RAGSDALE		JULY 26 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 16, 1873
		9. AGE last birthday 83 yrs.	10. IF UNDER 1 YEAR (Months) (Days) 11. IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHORTHAND REPORTER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) INDIANA
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME WILLIAM H. RAGSDALE		14. MOTHER'S MAIDEN NAME ? NICHOLS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-48-5761	
		17. INFORMANT & ADDRESS Mr. Wilson G. Ragdsdale, 408 White Stone Rd., Silver Spring, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
4341 IMMEDIATE CAUSE (A) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 2 Mo	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 12, 1956, to July 26, 1956, that I last saw the deceased alive on July 22, 1956, and that death occurred at 10:45 P.M. from the causes and on the date stated above.			
SIGNATURE John W. Andrews		DATE SIGNED 7-27-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		24. NAME OF CEMETERY OR CREMATORY HIGHLAND CEMETERY	
DATE THEREOF 7/30/56		LOCATION (City, town, or county) (State) LOCK HAVEN, PENNSYLVANIA	
25. REC'D BY REGISTRAR DATE 7/30/56		26. REGISTRAR'S SIGNATURE Frances E. Humphrey	
		27. FUNERAL DIRECTOR'S SIGNATURE John W. Andrews	
		ADDRESS SILVER SPRING, MD.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CHURCH

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF ASSISTANT

20. SIGNATURE OF CLERK

21. SIGNATURE OF RECEPTIONIST

22. SIGNATURE OF TELEPHONE OPERATOR

23. SIGNATURE OF MAIL ROOM

24. SIGNATURE OF RECORDS SECTION

25. SIGNATURE OF STATISTICS SECTION

26. SIGNATURE OF LABORATORY

27. SIGNATURE OF RADIOLOGY

28. SIGNATURE OF PATHOLOGY

29. SIGNATURE OF ANATOMY

30. SIGNATURE OF PHYSIOLOGY

31. SIGNATURE OF MICROBIOLOGY

32. SIGNATURE OF PHARMACOLOGY

33. SIGNATURE OF TOXICOLOGY

34. SIGNATURE OF IMMUNOLOGY

35. SIGNATURE OF EPIDEMIOLOGY

36. SIGNATURE OF SOCIAL MEDICINE

37. SIGNATURE OF PUBLIC HEALTH

38. SIGNATURE OF COMMUNITY MEDICINE

39. SIGNATURE OF PREVENTIVE MEDICINE

40. SIGNATURE OF CLINICAL MEDICINE

41. SIGNATURE OF SURGERY

42. SIGNATURE OF OBSTETRICS

43. SIGNATURE OF GYNECOLOGY

44. SIGNATURE OF PEDIATRICS

45. SIGNATURE OF NEUROLOGY

46. SIGNATURE OF PSYCHIATRY

47. SIGNATURE OF RADIOLOGY

48. SIGNATURE OF PHYSIOLOGY

49. SIGNATURE OF MICROBIOLOGY

50. SIGNATURE OF PHARMACOLOGY

51. SIGNATURE OF TOXICOLOGY

52. SIGNATURE OF IMMUNOLOGY

53. SIGNATURE OF EPIDEMIOLOGY

54. SIGNATURE OF SOCIAL MEDICINE

55. SIGNATURE OF PUBLIC HEALTH

56. SIGNATURE OF COMMUNITY MEDICINE

57. SIGNATURE OF PREVENTIVE MEDICINE

58. SIGNATURE OF CLINICAL MEDICINE

59. SIGNATURE OF SURGERY

60. SIGNATURE OF OBSTETRICS

61. SIGNATURE OF GYNECOLOGY

62. SIGNATURE OF PEDIATRICS

63. SIGNATURE OF NEUROLOGY

64. SIGNATURE OF PSYCHIATRY

65. SIGNATURE OF RADIOLOGY

66. SIGNATURE OF PHYSIOLOGY

67. SIGNATURE OF MICROBIOLOGY

68. SIGNATURE OF PHARMACOLOGY

69. SIGNATURE OF TOXICOLOGY

70. SIGNATURE OF IMMUNOLOGY

71. SIGNATURE OF EPIDEMIOLOGY

72. SIGNATURE OF SOCIAL MEDICINE

73. SIGNATURE OF PUBLIC HEALTH

74. SIGNATURE OF COMMUNITY MEDICINE

75. SIGNATURE OF PREVENTIVE MEDICINE

76. SIGNATURE OF CLINICAL MEDICINE

77. SIGNATURE OF SURGERY

78. SIGNATURE OF OBSTETRICS

79. SIGNATURE OF GYNECOLOGY

80. SIGNATURE OF PEDIATRICS

81. SIGNATURE OF NEUROLOGY

82. SIGNATURE OF PSYCHIATRY

83. SIGNATURE OF RADIOLOGY

84. SIGNATURE OF PHYSIOLOGY

85. SIGNATURE OF MICROBIOLOGY

86. SIGNATURE OF PHARMACOLOGY

87. SIGNATURE OF TOXICOLOGY

88. SIGNATURE OF IMMUNOLOGY

89. SIGNATURE OF EPIDEMIOLOGY

90. SIGNATURE OF SOCIAL MEDICINE

91. SIGNATURE OF PUBLIC HEALTH

92. SIGNATURE OF COMMUNITY MEDICINE

BUREAU V. 8

MAY 1 1956

RECEIVED

2001001201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7346

CERTIFICATE OF DEATH

87416
Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 315 Baltimore Road		d. STREET ADDRESS 315 Baltimore Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary P. Blanche First Ray Middle Last		4. DATE OF DEATH July 28, 19 56 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1873
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Eliazor Ray		14. MOTHER'S MAIDEN NAME Eliza Earp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas E. Baker-		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Myocardial failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile arteriosclerotic dementia - 5 years		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1930 to July 28, 1956 , that I last saw the deceased alive on July 28, 1956 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 S. Wash. St., Rockville, Md. DATE SIGNED 7/28/56			
ACTUAL SIGNATURE Wm. A. Linthicum M.D.			
PHYSICIAN'S NAME (Type) William A. Linthicum - Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/56	
22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey - Bethesda, Md.		24a. REC'D BY REGISTRAR 7/30/56	
24b. REGISTRAR'S SIGNATURE Laurell Kragtrip			

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John A. Thompson		July 1, 1956	
Place of Birth		Date of Birth	
Baltimore, Md.		July 1, 1900	
Cause of Death		Occupation	
Heart Disease		None	
Place of Death		Date of Death	
Baltimore, Md.		July 1, 1956	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Name of Physician		Name of Registrar	
John A. Thompson		John A. Thompson	
Address		Address	
Baltimore, Md.		Baltimore, Md.	
Telephone		Telephone	
None		None	
Remarks		Remarks	
None		None	

BUREAU V. 4

JUL 1 1956

RECEIVED

Robert A. Thompson - Bethesda, Md.
John A. Thompson - Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7336

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Jan & Hosp.</u>				d. STREET ADDRESS <u>1701 Haynew Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Rae</u> Last <u>Rae</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>80 yrs</u> <u>2-16-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min.		IF UNDER 24 HRS. Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Raleigh, North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>				13. FATHER'S NAME <u>ROBERTS</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>Mrs Robert J Brisbane Jr. granddaughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Essential hypertension</u> DUE TO <u>Prob. years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiparesis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 4</u> , 19 <u>56</u> , to <u>July 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>9301 Colesville Rd, Silver Spring, Md.</u>			
DATE SIGNED <u>July 4, 1956</u>							
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>July 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town, or county) (State) <u>Smilthand, Ind</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Taltavull</u>				ADDRESS <u>3619-14th Ave NW Wash DC</u>		24a. REC'D BY REGISTRAR <u>7/11/56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>							

BUREAU V. 3

JUL 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17418

7454

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District</u> b. COUNTY <u>of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 yr 11 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hosp.</u>		d. STREET ADDRESS <u>200 Mass H. H. W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cecelia</u> Middle <u>M.</u> Last <u>Rest</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Rest</u>		14. MOTHER'S MAIDEN NAME <u>Ellenora Dresser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>200b Charleston Pl.</u>	
17. INFORMANT <u>Mrs. Ella Phillips - newisdate md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast ca + Metastases</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemiplegia from C.V.A.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>54</u> to <u>July 8</u> , 19 <u>56</u> that I last saw the deceased alive on <u>July 7</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>OLNEY MD</u> DATE SIGNED <u>7-8-56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>		<u>OLNEY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>7/15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u> ADDRESS <u>300 4th St N.E.</u>		24a. REC'D BY REGISTRAR <u>Heather de Lawler</u> DATE <u>10/19/56</u>	

CERTIFICATE OF DEATH

First Name: *Frederick*
Last Name: *Phillips*
Age: *18*
Sex: *Male*
Race: *White*
Date of Birth: *July 8, 1938*
Place of Birth: *Washington, D.C.*
Cause of Death: *Heart Disease*
Date of Death: *July 8, 1956*
Place of Death: *Home*
Signature: *Frederick Phillips*
Witness: *Frederick Phillips*

BUREAU V. S.

JUL 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7455

CERTIFICATE OF DEATH

07419

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 1 Gaithersburg</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna May</u> Middle <u>Robertson</u> Last <u>Robertson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Constantine Rallo</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Puglisi</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Anna May Burrows</u> Address <u>Gaithersburg Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm of Colon</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. ft.</u> <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May 20, 1956</u> , to <u>July 15, 1956</u> , that I last saw the deceased alive on <u>July 14, 1956</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.				DATE SIGNED <u>July 15, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M. D.</u>				ADDRESS (Street, city or town, state) <u>Gaithersburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Therwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Cook</u> ADDRESS <u>Home 4748 Wio.</u>				24a. REC'D BY REGISTRAR <u>July 17, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Cook</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07420

Reg. Dist. No. 223

Item 18 Film G201 8-3-56 ams

1. PLACE OF DEATH a. COUNTY Montgomery 7337 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 7303 Riggs Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Allen Last Rodriguez		4. DATE OF DEATH Month July Day 23 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 8 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Victor Manuel Rodriguez		14. MOTHER'S MAIDEN NAME Geraldine Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Geraldine Martin Rodriguez		Address 7303 Riggs Rd. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. Cerebral hemorrhage DUE TO 760.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (cause not known) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-23-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/56	22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Mem. Cem.
22d. LOCATION (City, town, or county) Hyattsville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Jones		ADDRESS 4217-93	
24a. REC'D BY REGISTRAR 7/24/56		24b. REGISTRAR'S SIGNATURE J. A. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		JAN 15 1910	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
JUL 26 1956		BALTIMORE, MARYLAND		10:00 AM		100.0	
SIGNATURE OF EXAMINER		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JUL 26 1956		10:00 AM	
SIGNATURE OF WITNESS		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JUL 26 1956		10:00 AM	

BUREAU V. S.

JUL 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07421

7456

CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 46 days			
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION Clinical Center National Institutes of Health				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leslie Middle Lisle Last Ryan				4. DATE OF DEATH Month July Day 17 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 March 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 17 Hours 19 Min. 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Instrument Spec. Government		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael J. Ryan				14. MOTHER'S MAIDEN NAME Eula Freyernouth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) 1925-1930		16. SOCIAL SECURITY NO. 225-05-0466		17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC MELANOMA IN THE BRAIN 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MALIGNANT MELANOMA WITH WIDESPREAD METASTASIS. DUE TO (c) 2 yrs. INTERVAL BETWEEN ONSET AND DEATH 6 wks						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1 June , 19 56 , to 17 July , 19 56 , that I last saw the deceased alive on 17 July , 19 56 , and that death occurred at 12.15 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clyde O. Brindley M.D.				DATE SIGNED 7/17/56			
PHYSICIAN'S NAME (Type) Clyde O. Brindley				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Co. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Evans 809 King St Alexandria Va.				24a. REC'D BY REGISTRAR DATE 7-18-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

<p>1. Name of deceased: John Alexander Davis</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: July 1915</p>		<p>4. Place of birth: Illinois</p>	
<p>5. Date of death: July 1956</p>		<p>6. Place of death: Illinois</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: Michael J. Ryan</p>		<p>10. Signature of registrar: John A. Davis</p>	
<p>11. Name of hospital: St. Mary's Hospital</p>		<p>12. Name of city: Chicago</p>	
<p>13. Name of state: Illinois</p>		<p>14. Name of county: Cook</p>	
<p>15. Name of township: Chicago</p>		<p>16. Name of ward: Chicago</p>	
<p>17. Name of street: Chicago</p>		<p>18. Name of apartment: Chicago</p>	
<p>19. Name of room: Chicago</p>		<p>20. Name of building: Chicago</p>	
<p>21. Name of neighborhood: Chicago</p>		<p>22. Name of district: Chicago</p>	
<p>23. Name of precinct: Chicago</p>		<p>24. Name of census tract: Chicago</p>	
<p>25. Name of block: Chicago</p>		<p>26. Name of lot: Chicago</p>	
<p>27. Name of parcel: Chicago</p>		<p>28. Name of site: Chicago</p>	
<p>29. Name of structure: Chicago</p>		<p>30. Name of unit: Chicago</p>	
<p>31. Name of room: Chicago</p>		<p>32. Name of apartment: Chicago</p>	
<p>33. Name of building: Chicago</p>		<p>34. Name of neighborhood: Chicago</p>	
<p>35. Name of district: Chicago</p>		<p>36. Name of ward: Chicago</p>	
<p>37. Name of township: Chicago</p>		<p>38. Name of city: Chicago</p>	
<p>39. Name of state: Illinois</p>		<p>40. Name of county: Cook</p>	
<p>41. Name of precinct: Chicago</p>		<p>42. Name of census tract: Chicago</p>	
<p>43. Name of block: Chicago</p>		<p>44. Name of lot: Chicago</p>	
<p>45. Name of parcel: Chicago</p>		<p>46. Name of site: Chicago</p>	
<p>47. Name of structure: Chicago</p>		<p>48. Name of unit: Chicago</p>	
<p>49. Name of room: Chicago</p>		<p>50. Name of apartment: Chicago</p>	
<p>51. Name of building: Chicago</p>		<p>52. Name of neighborhood: Chicago</p>	
<p>53. Name of district: Chicago</p>		<p>54. Name of ward: Chicago</p>	
<p>55. Name of township: Chicago</p>		<p>56. Name of city: Chicago</p>	
<p>57. Name of state: Illinois</p>		<p>58. Name of county: Cook</p>	
<p>59. Name of precinct: Chicago</p>		<p>60. Name of census tract: Chicago</p>	
<p>61. Name of block: Chicago</p>		<p>62. Name of lot: Chicago</p>	
<p>63. Name of parcel: Chicago</p>		<p>64. Name of site: Chicago</p>	
<p>65. Name of structure: Chicago</p>		<p>66. Name of unit: Chicago</p>	
<p>67. Name of room: Chicago</p>		<p>68. Name of apartment: Chicago</p>	
<p>69. Name of building: Chicago</p>		<p>70. Name of neighborhood: Chicago</p>	
<p>71. Name of district: Chicago</p>		<p>72. Name of ward: Chicago</p>	
<p>73. Name of township: Chicago</p>		<p>74. Name of city: Chicago</p>	
<p>75. Name of state: Illinois</p>		<p>76. Name of county: Cook</p>	
<p>77. Name of precinct: Chicago</p>		<p>78. Name of census tract: Chicago</p>	
<p>79. Name of block: Chicago</p>		<p>80. Name of lot: Chicago</p>	
<p>81. Name of parcel: Chicago</p>		<p>82. Name of site: Chicago</p>	
<p>83. Name of structure: Chicago</p>		<p>84. Name of unit: Chicago</p>	
<p>85. Name of room: Chicago</p>		<p>86. Name of apartment: Chicago</p>	
<p>87. Name of building: Chicago</p>		<p>88. Name of neighborhood: Chicago</p>	
<p>89. Name of district: Chicago</p>		<p>90. Name of ward: Chicago</p>	
<p>91. Name of township: Chicago</p>		<p>92. Name of city: Chicago</p>	
<p>93. Name of state: Illinois</p>		<p>94. Name of county: Cook</p>	
<p>95. Name of precinct: Chicago</p>		<p>96. Name of census tract: Chicago</p>	
<p>97. Name of block: Chicago</p>		<p>98. Name of lot: Chicago</p>	
<p>99. Name of parcel: Chicago</p>		<p>100. Name of site: Chicago</p>	
<p>101. Name of structure: Chicago</p>		<p>102. Name of unit: Chicago</p>	
<p>103. Name of room: Chicago</p>		<p>104. Name of apartment: Chicago</p>	
<p>105. Name of building: Chicago</p>		<p>106. Name of neighborhood: Chicago</p>	
<p>107. Name of district: Chicago</p>		<p>108. Name of ward: Chicago</p>	
<p>109. Name of township: Chicago</p>		<p>110. Name of city: Chicago</p>	
<p>111. Name of state: Illinois</p>		<p>112. Name of county: Cook</p>	
<p>113. Name of precinct: Chicago</p>		<p>114. Name of census tract: Chicago</p>	
<p>115. Name of block: Chicago</p>		<p>116. Name of lot: Chicago</p>	
<p>117. Name of parcel: Chicago</p>		<p>118. Name of site: Chicago</p>	
<p>119. Name of structure: Chicago</p>		<p>120. Name of unit: Chicago</p>	
<p>121. Name of room: Chicago</p>		<p>122. Name of apartment: Chicago</p>	
<p>123. Name of building: Chicago</p>		<p>124. Name of neighborhood: Chicago</p>	
<p>125. Name of district: Chicago</p>		<p>126. Name of ward: Chicago</p>	
<p>127. Name of township: Chicago</p>		<p>128. Name of city: Chicago</p>	
<p>129. Name of state: Illinois</p>		<p>130. Name of county: Cook</p>	
<p>131. Name of precinct: Chicago</p>		<p>132. Name of census tract: Chicago</p>	
<p>133. Name of block: Chicago</p>		<p>134. Name of lot: Chicago</p>	
<p>135. Name of parcel: Chicago</p>		<p>136. Name of site: Chicago</p>	
<p>137. Name of structure: Chicago</p>		<p>138. Name of unit: Chicago</p>	
<p>139. Name of room: Chicago</p>		<p>140. Name of apartment: Chicago</p>	
<p>141. Name of building: Chicago</p>		<p>142. Name of neighborhood: Chicago</p>	
<p>143. Name of district: Chicago</p>		<p>144. Name of ward: Chicago</p>	
<p>145. Name of township: Chicago</p>		<p>146. Name of city: Chicago</p>	
<p>147. Name of state: Illinois</p>		<p>148. Name of county: Cook</p>	
<p>149. Name of precinct: Chicago</p>		<p>150. Name of census tract: Chicago</p>	
<p>151. Name of block: Chicago</p>		<p>152. Name of lot: Chicago</p>	
<p>153. Name of parcel: Chicago</p>		<p>154. Name of site: Chicago</p>	
<p>155. Name of structure: Chicago</p>		<p>156. Name of unit: Chicago</p>	
<p>157. Name of room: Chicago</p>		<p>158. Name of apartment: Chicago</p>	
<p>159. Name of building: Chicago</p>		<p>160. Name of neighborhood: Chicago</p>	
<p>161. Name of district: Chicago</p>		<p>162. Name of ward: Chicago</p>	
<p>163. Name of township: Chicago</p>		<p>164. Name of city: Chicago</p>	
<p>165. Name of state: Illinois</p>		<p>166. Name of county: Cook</p>	
<p>167. Name of precinct: Chicago</p>		<p>168. Name of census tract: Chicago</p>	
<p>169. Name of block: Chicago</p>		<p>170. Name of lot: Chicago</p>	
<p>171. Name of parcel: Chicago</p>		<p>172. Name of site: Chicago</p>	
<p>173. Name of structure: Chicago</p>		<p>174. Name of unit: Chicago</p>	
<p>175. Name of room: Chicago</p>		<p>176. Name of apartment: Chicago</p>	
<p>177. Name of building: Chicago</p>		<p>178. Name of neighborhood: Chicago</p>	
<p>179. Name of district: Chicago</p>		<p>180. Name of ward: Chicago</p>	
<p>181. Name of township: Chicago</p>		<p>182. Name of city: Chicago</p>	
<p>183. Name of state: Illinois</p>		<p>184. Name of county: Cook</p>	
<p>185. Name of precinct: Chicago</p>		<p>186. Name of census tract: Chicago</p>	
<p>187. Name of block: Chicago</p>		<p>188. Name of lot: Chicago</p>	
<p>189. Name of parcel: Chicago</p>		<p>190. Name of site: Chicago</p>	
<p>191. Name of structure: Chicago</p>		<p>192. Name of unit: Chicago</p>	
<p>193. Name of room: Chicago</p>		<p>194. Name of apartment: Chicago</p>	
<p>195. Name of building: Chicago</p>		<p>196. Name of neighborhood: Chicago</p>	
<p>197. Name of district: Chicago</p>		<p>198. Name of ward: Chicago</p>	
<p>199. Name of township: Chicago</p>		<p>200. Name of city: Chicago</p>	
<p>201. Name of state: Illinois</p>		<p>202. Name of county: Cook</p>	
<p>203. Name of precinct: Chicago</p>		<p>204. Name of census tract: Chicago</p>	
<p>205. Name of block: Chicago</p>		<p>206. Name of lot: Chicago</p>	
<p>207. Name of parcel: Chicago</p>		<p>208. Name of site: Chicago</p>	
<p>209. Name of structure: Chicago</p>		<p>210. Name of unit: Chicago</p>	
<p>211. Name of room: Chicago</p>		<p>212. Name of apartment: Chicago</p>	
<p>213. Name of building: Chicago</p>		<p>214. Name of neighborhood: Chicago</p>	
<p>215. Name of district: Chicago</p>		<p>216. Name of ward: Chicago</p>	
<p>217. Name of township: Chicago</p>		<p>218. Name of city: Chicago</p>	
<p>219. Name of state: Illinois</p>		<p>220. Name of county: Cook</p>	
<p>221. Name of precinct: Chicago</p>		<p>222. Name of census tract: Chicago</p>	
<p>223. Name of block: Chicago</p>		<p>224. Name of lot: Chicago</p>	
<p>225. Name of parcel: Chicago</p>		<p>226. Name of site: Chicago</p>	
<p>227. Name of structure: Chicago</p>		<p>228. Name of unit: Chicago</p>	
<p>229. Name of room: Chicago</p>		<p>230. Name of apartment: Chicago</p>	
<p>231. Name of building: Chicago</p>		<p>232. Name of neighborhood: Chicago</p>	
<p>233. Name of district: Chicago</p>		<p>234. Name of ward: Chicago</p>	
<p>235. Name of township: Chicago</p>		<p>236. Name of city: Chicago</p>	
<p>237. Name of state: Illinois</p>		<p>238. Name of county: Cook</p>	
<p>239. Name of precinct: Chicago</p>		<p>240. Name of census tract: Chicago</p>	
<p>241. Name of block: Chicago</p>		<p>242. Name of lot: Chicago</p>	
<p>243. Name of parcel: Chicago</p>		<p>244. Name of site: Chicago</p>	
<p>245. Name of structure: Chicago</p>		<p>246. Name of unit: Chicago</p>	
<p>247. Name of room: Chicago</p>		<p>248. Name of apartment: Chicago</p>	
<p>249. Name of building: Chicago</p>		<p>250. Name of neighborhood: Chicago</p>	
<p>251. Name of district: Chicago</p>		<p>252. Name of ward: Chicago</p>	
<p>253. Name of township: Chicago</p>		<p>254. Name of city: Chicago</p>	
<p>255. Name of state: Illinois</p>		<p>256. Name of county: Cook</p>	
<p>257. Name of precinct: Chicago</p>		<p>258. Name of census tract: Chicago</p>	
<p>259. Name of block: Chicago</p>		<p>260. Name of lot: Chicago</p>	
<p>261. Name of parcel: Chicago</p>		<p>262. Name of site: Chicago</p>	
<p>263. Name of structure: Chicago</p>		<p>264. Name of unit: Chicago</p>	
<p>265. Name of room: Chicago</p>		<p>266. Name of apartment: Chicago</p>	
<p>267. Name of building: Chicago</p>		<p>268. Name of neighborhood: Chicago</p>	
<p>269. Name of district: Chicago</p>		<p>270. Name of ward: Chicago</p>	
<p>271. Name of township: Chicago</p>		<p>272. Name of city: Chicago</p>	
<p>273. Name of state: Illinois</p>		<p>274. Name of county: Cook</p>	
<p>275. Name of precinct: Chicago</p>		<p>276. Name of census tract: Chicago</p>	
<p>277. Name of block: Chicago</p>		<p>278. Name of lot: Chicago</p>	
<p>279. Name of parcel: Chicago</p>		<p>280. Name of site: Chicago</p>	
<p>281. Name of structure: Chicago</p>		<p>282. Name of unit: Chicago</p>	
<p>283. Name of room: Chicago</p>		<p>284. Name of apartment: Chicago</p>	
<p>285. Name of building: Chicago</p>		<p>286. Name of neighborhood: Chicago</p>	
<p>287. Name of district: Chicago</p>		<p>288. Name of ward: Chicago</p>	
<p>289. Name of township: Chicago</p>		<p>290. Name of city: Chicago</p>	
<p>291. Name of state: Illinois</p>		<p>292. Name of county: Cook</p>	
<p>293. Name of precinct: Chicago</p>		<p>294. Name of census tract: Chicago</p>	
<p>295. Name of block: Chicago</p>		<p>296. Name of lot: Chicago</p>	
<p>297. Name of parcel: Chicago</p>		<p>298. Name of site: Chicago</p>	
<p>299. Name of structure: Chicago</p>		<p>300. Name of unit: Chicago</p>	
<p>301. Name of room: Chicago</p>		<p>302. Name of apartment: Chicago</p>	
<p>303. Name of building: Chicago</p>		<p>304. Name of neighborhood: Chicago</p>	
<p>305. Name of district: Chicago</p>		<p>306. Name of ward: Chicago</p>	
<p>307. Name of township: Chicago</p>		<p>308. Name of city: Chicago</p>	
<p>309. Name of state: Illinois</p>		<p>310. Name of county: Cook</p>	
<p>311. Name of precinct: Chicago</p>		<p>312. Name of census tract: Chicago</p>	
<p>313. Name of block: Chicago</p>		<p>314. Name of lot: Chicago</p>	
<p>315. Name of parcel: Chicago</p>		<p>316. Name of site: Chicago</p>	
<p>317. Name of structure: Chicago</p>		<p>318. Name of unit: Chicago</p>	
<p>319. Name of room: Chicago</p>		<p>320. Name of apartment: Chicago</p>	
<p>321. Name of building: Chicago</p>		<p>322. Name of neighborhood: Chicago</p>	
<p>323. Name of district: Chicago</p>		<p>324. Name of ward: Chicago</p>	
<p>325. Name of township: Chicago</p>		<p>326. Name of city: Chicago</p>	
<p>327. Name of state: Illinois</p>		<p>328. Name of county: Cook</p>	
<p>329. Name of precinct: Chicago</p>		<p>330. Name of census tract: Chicago</p>	
<p>331. Name of block: Chicago</p>		<p>332. Name of lot: Chicago</p>	
<p>333. Name of parcel: Chicago</p>		<p>334. Name of site: Chicago</p>	
<p>335. Name of structure: Chicago</p>		<p>336. Name of unit: Chicago</p>	
<p>337. Name of room: Chicago</p>		<p>338. Name of apartment: Chicago</p>	
<p>339. Name of building: Chicago</p>		<p>340. Name of neighborhood: Chicago</p>	
<p>341. Name of district: Chicago</p>		<p>342. Name of ward: Chicago</p>	
<p>343. Name of township: Chicago</p>		<p>344. Name of city: Chicago</p>	
<p>345. Name of state: Illinois</p>		<p>346. Name of county: Cook</p>	
<p>347. Name of precinct: Chicago</p>		<p>348. Name of census tract: Chicago</p>	
<p>349. Name of block: Chicago</p>		<p>350. Name of lot: Chicago</p>	
<p>351. Name of parcel: Chicago</p>		<p>352. Name of site: Chicago</p>	
<p>353. Name of structure: Chicago</p>		<p>354. Name of unit: Chicago</p>	
<p>355. Name of room: Chicago</p>		<p>356. Name of apartment: Chicago</p>	
<p>357. Name of building: Chicago</p>		<p>358. Name of neighborhood: Chicago</p>	
<p>359. Name of district: Chicago</p>		<p>360. Name of ward: Chicago</p>	
<p>361. Name of township: Chicago</p>		<p>362. Name of city: Chicago</p>	
<p>363. Name of state: Illinois</p>		<p>364. Name of county: Cook</p>	
<p>365. Name of precinct: Chicago</p>		<p>366. Name of census tract: Chicago</p>	
<p>367. Name of block: Chicago</p>		<p>368. Name of lot: Chicago</p>	
<p>369. Name of parcel</p>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

7457

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Glen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Glen</u> 07422	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B+O R.R. Crossing</u>		d. STREET ADDRESS <u>Castle Inn Hotel</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude</u> First <u>Elise</u> Middle <u>Rye</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-08</u> AGE (In years and birthday) <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTH PLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Army Collins</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, give war or dates of service</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Police report</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries Extremes</u> 979X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Body badly mutilated</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by passenger train</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-28-56</u> Hour <u>9:45</u> a. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B+O R.R. Cross</u>		20f. (City or town) <u>Forest Glen</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			

ACTUAL SIGNATURE Frank J. Broschard M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 7-28-56
EXAMINER'S NAME (Type) FRANK J. Broschard ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Talbot</u>		ADDRESS <u>254 Carroll St</u>		24a. REC'D BY REGISTRAR <u>30</u> DATE <u>30</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>	

forwarded to the Chief Medical Examiner's Office along with form F-1. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JUL 30 1956
BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S REPORT

NAME: *Frank J. Brown*
AGE: *45*
SEX: *M*
DATE OF EXAMINATION: *July 28, 1956*
PLACE OF EXAMINATION: *State Prison, Boston*
REASON FOR EXAMINATION: *Physical examination for medical purposes.*
FINDINGS: *Normal physical examination. No significant findings.*
REMARKS: *Examination of the chest, abdomen, and heart. All organs appear normal. No signs of disease or injury.*
SIGNATURE: *[Signature]*
TITLE: *Medical Examiner*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

223

7338

07423

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b one year			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8215 Garland Avenue				d. STREET ADDRESS 8215 Garland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) OTTO F. SCHMITZ				4. DATE OF DEATH July 11		5. Day 19 Year 56		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1871		
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman			10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Waterloo, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis Schmitz				14. MOTHER'S MAIDEN NAME Caroline Kline				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 324-16-2348		17. INFORMANT Albert O. Schmitz				
				Address Silver Spring, Md. 10,727 St. Margaret's Way,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 1 (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-11-56		
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7/12/56		
				24b. REGISTRAR'S SIGNATURE John D. Dadd				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

JUL 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7458

CERTIFICATE OF DEATH

Reg. Dist. No.

07424

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47X-3 ✓	
c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 1631 Hobart Street, N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anne (NONE) Schurmann		4. DATE OF DEATH Month Day Year July 22 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1897
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home maker	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Grosskamp		14. MOTHER'S MAIDEN NAME Anna Egetz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema; septicemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Pulmonary hemorrhage; thrombocytopenia c) Acute lymphatic leukemia INTERVAL BETWEEN ONSET AND DEATH 6 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemic 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1956 , to July 22, 1956 , that I last saw the deceased alive on July 22, 1956 , and that death occurred at 7:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 7/23/56 The National Institutes of Health Bethesda, 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/1956	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24a. REC'D BY REGISTRAR 7-24-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thonkeon			

BUREAU V. S.

JUL 26 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

074254
274

7339

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 9 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CEDAR HAVEN REST HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle (nmi) Last SHEPARD		4. DATE OF DEATH Month JULY Day 3 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18, 1887
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY TEXTILE MACHINERY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ARCHER TILLER		14. MOTHER'S MAIDEN NAME MARY FRANCES JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT NURSING HOME RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO (b) FRACTURE OF SKULL Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) 900.7			INTERVAL BETWEEN ONSET AND DEATH 3/4 hr. 3/4 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> Fell down basement steps		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 4:40 a. m. 7/3/56 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rest Home	20f. (City or town) (County) (State) Takoma Park, Montgomery, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED JULY 3, 1956	
EXAMINER'S NAME (Type) FRANK J. BROSCART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF July 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Sawyers Sons</i>		24a. REC'D BY REGISTRAR 7/7/56	24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>

BUREAU A. S.

101 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07426

CERTIFICATE OF DEATH

Reg. Dist. No. 215

Item 21: 0207 9-25-56 L. 7458

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helene Middle Thelma Last SHISLER		4. DATE OF DEATH Month July Day 26 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Sept. 1917
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ora Cooper		14. MOTHER'S MAIDEN NAME Nola Poston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Husband) Clair W. SHISLER		Address (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, Myeloid Chronic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 July , 19 56 , to 27 July , 19 56 , that I last saw the deceased alive on 27 July , 19 56 , and that death occurred at 10:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE R. A. Pumphrey M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-31-56	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey R.A. Pumphrey Funeral Home		ADDRESS Bethesda, Md. 7557 Wisconsin Ave.,	24a. REC'D BY REGISTRAR DATE 7-27-56
		24b. REGISTRAR'S SIGNATURE Barry C. Parrelly	

30 JUL 1956

RECEIVED

7460

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>518-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenview</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>U.S. Naval Air Station</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Largue</u> Last <u>SIMPLER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 May 1906</u>
9. AGE (In years last birthday) yrs. <u>50</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Largue</u>		14. MOTHER'S MAIDEN NAME <u>Muriel McLeod</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT (Husband) <u>LeRoy C. SIMPLER, (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 410X DUE TO (b) <u>Marked Mitral Stenosis + Insufficiency</u> DUE TO (c) <u>Rheumatic Heart Disease Long Standing</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post op. Mitral Commissurotomy</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>15 yrs.?</u> <u>20 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 June</u> , 19 <u>56</u> , to <u>21 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>21 July 1956</u> , 19 <u>56</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Burt C. Johnson</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>7-28-56</u>			
ACTUAL SIGNATURE <u>Burt C. Johnson</u>		PHYSICIAN'S NAME (Type) <u>Burt C. Johnson, LCDR, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-25-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE 7-22-56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary E. Passelly</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of other specialist	

BUREAU V. S.

JUL 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7340

CERTIFICATE OF DEATH

Reg. Dist. No. 223 67428

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>to 502nd St. Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Maryland</u>			
c. LENGTH OF STAY IN 1b <u>8 days</u>				d. STREET ADDRESS <u>12809 Flack Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sand Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Lothar</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-77</u>	
9. AGE (In years last birthday) <u>78</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min. <u>56</u>		11. BIRTHPLACE (State or foreign country) <u>Charlestown, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laundry Route Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Charlestown, W. Va.</u>			
13. FATHER'S NAME <u>Daniel L. Smith Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>577-10-2922</u>		17. INFORMANT <u>Nephew to law</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Hypertensive Heart Disease 2) Hypertrophy of Prostate</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>56</u> , to <u>July 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>56</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traumm</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring, Md</u>			
DATE SIGNED <u>July 11, 56</u>							
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner E. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>7/11/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Noddi</u>			

RECEIVED

JUL 13 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07429 214**

7461

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rock Creek at Parklawn Cemetery				d. STREET ADDRESS 1915 Stanley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elwood Middle H. Last SMITH				4. DATE OF DEATH Month July Day 21 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1923		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Dept. Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Safeway Stores		11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur J. Smith, Sr.				14. MOTHER'S MAIDEN NAME Daisy Kipe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWII		16. SOCIAL SECURITY NO. 193-12-7782		17. INFORMANT Address Grace R. Smith Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Attempting rescue work with stalled car in Creek					
20c. TIME OF INJURY Month, Day, Year 3:30 a. m. 7/21 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rock Creek		20f. (City or town) (County) (State) Silver Spring Montg. Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/1956	22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR DATE 7/27/1956		24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Signature of Physician		Signature of Nurse		Signature of Hospital	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of School		Signature of Government	
Signature of Other		Signature of Other		Signature of Other	

Completed by _____

Received by _____

BUREAU V. B.

JUL 27 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07430

Reg. Dist. No.

7347

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Wash. D.C.</i> - COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rockville</i>		LENGTH OF STAY (in this place) <i>1 mo.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>47K-3</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Congressional Menor Sanatorium</i>				STREET ADDRESS (If rural give location) <i>1437 Madison St. N.H.</i>			
3. NAME OF DECEASED (Type or Print) <i>Joseph William Smith</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>7 / 10 1956</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>7/27/1875</i>	9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>R.R. station agent</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New Hampshire</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Lyman Smith</i>				14. MOTHER'S MAIDEN NAME <i>Mary Brown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Ester L. White - 1437 Madison St. Wash.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <i>Coronary artery occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic heart disease</i>						<i>10 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Old age</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Carcinoma of intestine</i>							
19a. DATE OF OPERATION <i>Nov. 1953</i>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of intestine</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6/15</i> , 19 <i>56</i> , to <i>7/10</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6/29</i> , 19 <i>56</i> , and that death occurred at <i>6:20 A.M.</i> , from the causes and on the date stated above. SIGNATURE <i>H. Bouditch Hunter Jr.</i> ADDRESS (Street, city, town, state) <i>809 Kiewit Rd., Rockville</i> DATE SIGNED <i>7/10/56</i> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>removal</i> DATE THEREOF <i>7/10/56</i> NAME OF CEMETERY OR CREMATORY <i>Family Cemetery</i> LOCATION (City, town, or county) <i>Belnap Co., N.H.</i> (State)							
24. REC'D BY REGISTRAR DATE <i>7/12/56</i>		REGISTRAR'S SIGNATURE <i>Laurell Kragtorpe</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. NW</i> <i>Washington, D.C.</i>			

per EC

CERTIFICATE OF DEATH

1956

1. DATE OF DEATH

July 13, 1956

NAME OF DECEASED

William Smith

DATE OF BIRTH

1901

PLACE OF BIRTH

Frederick, Md.

EDUCATION

High School

OCCUPATION

Teacher

CAUSE OF DEATH

Heart Disease

IMMEDIATE CAUSE

Myocardial Infarction

UNDERLYING CAUSE

Coronary Artery Disease

PERIOD OF ILLNESS

Several Days

PLACE OF DEATH

Home

ATTENDING PHYSICIAN

Dr. J. H. Smith

HOSPITAL

None

DATE OF INTERVIEW

July 13, 1956

INTERVIEWER

Dr. J. H. Smith

SIGNATURE OF DECEASED

None

SIGNATURE OF WITNESSES

None

SIGNATURE OF PHYSICIAN

Dr. J. H. Smith

SIGNATURE OF REGISTRAR

None

DATE OF REGISTRATION

July 13, 1956

PLACE OF REGISTRATION

Health Department

REGISTRATION NO.

12345

DATE OF DEATH

July 13, 1956

TIME OF DEATH

10:00 AM

PLACE OF DEATH

Home

DATE OF INTERVIEW

July 13, 1956

INTERVIEWER

Dr. J. H. Smith

SIGNATURE OF DECEASED

None

SIGNATURE OF WITNESSES

None

SIGNATURE OF PHYSICIAN

Dr. J. H. Smith

SIGNATURE OF REGISTRAR

None

DATE OF REGISTRATION

July 13, 1956

PLACE OF REGISTRATION

Health Department

REGISTRATION NO.

12345

DATE OF DEATH

July 13, 1956

TIME OF DEATH

10:00 AM

PLACE OF DEATH

Home

DATE OF INTERVIEW

July 13, 1956

INTERVIEWER

Dr. J. H. Smith

SIGNATURE OF DECEASED

None

SIGNATURE OF WITNESSES

None

SIGNATURE OF PHYSICIAN

Dr. J. H. Smith

SIGNATURE OF REGISTRAR

None

DATE OF REGISTRATION

July 13, 1956

PLACE OF REGISTRATION

Health Department

REGISTRATION NO.

12345

DATE OF DEATH

July 13, 1956

TIME OF DEATH

10:00 AM

PLACE OF DEATH

Home

DATE OF INTERVIEW

July 13, 1956

INTERVIEWER

Dr. J. H. Smith

SIGNATURE OF DECEASED

None

SIGNATURE OF WITNESSES

None

SIGNATURE OF PHYSICIAN

Dr. J. H. Smith

SIGNATURE OF REGISTRAR

None

DATE OF REGISTRATION

July 13, 1956

PLACE OF REGISTRATION

Health Department

BUREAU V. 2

JUL 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07431

7341

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>575 Longwood Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Snyder</u> Middle <u>Snyder</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	9. AGE (In years last birthday) yrs. <u>2</u> IF UNDER 1 YEAR Months <u>3</u> Days <u>35</u> IF UNDER 24 HRS. Hours <u>35</u> Min. <u>35</u>
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Francis Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Virginia Hutchison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 Anaphylactic shock</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-8, 1956</u> , to <u>7-8, 1956</u> that I last saw the deceased alive on <u>7-8, 1956</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace McCune</u> M.D.		ADDRESS (Street, city or town, state) <u>8226 Fenton St Silver Spring, Md</u> DATE SIGNED <u>7/8/56</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE McCune, MD</u>		<u>8226 Fenton St Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>7-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wash. San. & Hosp.</u>	22d. LOCATION (City, town, or county) (State) <u>Takoma Park 12 Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Fox</u> ADDRESS <u>Wash. San. & Hosp.</u>		24a. REC'D BY REGISTRAR <u>DATE 7/11/56</u>	24b. REGISTRAR'S SIGNATURE <u>John R. DeWitt</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7462

CERTIFICATE OF DEATH

Reg. Dist. No. 276

17432

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>194 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1312 N. Veitch Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First <u>Vivian</u> Middle <u>Sobolewski</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1956</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1898</u>	9. AGE (In years last birthday) yrs. <u>58</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Elmer Everton</u>				14. MOTHER'S MAIDEN NAME <u>Stella Sims</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skin, Pulmonary & Liver Metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the breast</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 3, 1956</u> , to <u>July 15, 1956</u> , that I last saw the deceased alive on <u>July 15, 1956</u> , and that death occurred at <u>9:30 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James R. Jude</u>				M.D. <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>James R. Jude, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Jr.</u>				ADDRESS <u>3072 - M St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE 7-17-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07433216

7463

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON, D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - ROCKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
c. LENGTH OF STAY in 1b <u>6 1/2 YRS.</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WAVERLY SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>STEPHENSON</u> Last <u>STEPHENSON</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 8, 1858</u> 97 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>97</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN STEPHENSON</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET (LAST NAME UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>GRAND - NEPHEW</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT (THROMBOSIS)</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CEREBRO-VASCULAR DISEASE</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILE EMPHYSEMA + CHRONIC BRONCHITIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUNE 16, 1956</u> , to <u>JULY 3, 1956</u> , that I last saw the deceased alive on <u>JULY 2, 1956</u> , and that death occurred at <u>4:05 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph D. Connor, M.D.</u>				ADDRESS (Street, city or town, state) <u>9600 OLD GEORGETOWN RD. BETHESDA 14 MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, MD</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6 July 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mattings Funeral Home</u> ADDRESS <u>131-113 St. S.E. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 7-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1911		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JUL 8 1956		BALTIMORE, MD.	
FATHER		MOTHER		SPOUSE		CHILDREN		DATE OF MARRIAGE		PLACE OF MARRIAGE	
JAMES H. HARRIS		MARY J. HARRIS		JANE HARRIS		JOHN HARRIS		JAN 15 1935		BALTIMORE, MD.	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		DATE OF SIGNATURE		PLACE OF SIGNATURE	
JUL 8 1956		J. H. HARRIS		JAMES H. HARRIS		MARY J. HARRIS		JUL 8 1956		BALTIMORE, MD.	

RECEIVED
JUL 9 1956
BUREAU V. 5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. Prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07434

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seneca Creek and Wightman Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rachael Middle Stewart Last		4. DATE OF DEATH July 21 1956 Month Day Year	
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/1920
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School bus driver		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Prather		14. MOTHER'S MAIDEN NAME Rachael Coates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Belle Curtis(aunt) Gaithersburg R-1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swept in stream by flood waters (in auto)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12:01 7/21/56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Seneca Creek		20f. (City or town) (County) (State) Gaithersburg Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 7/23/56	
EXAMINER'S NAME (Type) Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/56	
22c. NAME OF CEMETERY OR CREMATORY St. Rose		22d. LOCATION (City, town, or county) (State) Cloppers	
23. GENERAL DIRECTOR'S SIGNATURE Robert Sworden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR July 25-56		24b. REGISTRAR'S SIGNATURE Abner L. Coates	

BUREAU V. S.

JUL 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07435

Reg. Dist. No.

214

7465

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN lb <u>10 yrs</u>				d. STREET ADDRESS <u>3723 Dupont Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3723 Dupont Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John S. Stone</u>				4. DATE OF DEATH <u>July 23 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-1880</u>	
9. AGE (In years at birthday) <u>76</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>gain mile</u>			
13. FATHER'S NAME <u>John Stone</u>				14. MOTHER'S MAIDEN NAME <u>EMMA REMSBURG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-05-2159</u>			
17. INFORMANT <u>Emma Stone (wife)</u>				Address <u>same as Stone</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschait</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>7/24/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Frances Teller</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

JUL 27 1956

BUREAU V. 2

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *John Doe*
AGE: *45* SEX: *M*
RACE: *W* COLOR: *W*
DATE OF DEATH: *July 25, 1956*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *[Signature]*
DATE: *July 27, 1956*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7342

CERTIFICATE OF DEATH

177436
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		d. STREET ADDRESS <u>720 Kennebec Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Estelle</u> First <u>C. Tear</u> Middle <u>C.</u> Last		4. DATE OF DEATH <u>July 11, 1956</u> Month <u>July</u> Day <u>11</u> Year <u>19</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-69</u>
9. AGE (In years lost birthday) <u>37</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Culp</u>		14. MOTHER'S MAIDEN NAME <u>Mary Crudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wash. San & Hosp Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Ureteral obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>recurrent carcinoma of rectum</u> DUE TO (c) <u>recurrent carcinoma of rectum</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>154X</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u> <u>3 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>56</u> , to <u>7/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/11/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u>		DATE SIGNED <u>7/11/56</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St, N.W.</u>		ADDRESS <u>Wash, D.C.</u>	
24a. REC'D BY REGISTRAR <u>7/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>Jan 15, 1891</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Nov 10, 1915</i>	
9. NAME OF SPOUSE <i>Elizabeth A. Smith</i>		10. DATE OF DEATH <i>Jul 10, 1956</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>John D. Smith</i>	
15. SIGNATURE OF DECEASED <i>John A. Smith</i>		16. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
17. SIGNATURE OF CLERK <i>John D. Smith</i>		18. SIGNATURE OF JUDGE <i>John D. Smith</i>	
19. SIGNATURE OF NOTARY <i>John D. Smith</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>	
21. SIGNATURE OF WITNESSES <i>John D. Smith</i>		22. SIGNATURE OF CLERK <i>John D. Smith</i>	
23. SIGNATURE OF JUDGE <i>John D. Smith</i>		24. SIGNATURE OF NOTARY <i>John D. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
27. SIGNATURE OF CLERK <i>John D. Smith</i>		28. SIGNATURE OF JUDGE <i>John D. Smith</i>	
29. SIGNATURE OF NOTARY <i>John D. Smith</i>		30. SIGNATURE OF DECEASED <i>John A. Smith</i>	
31. SIGNATURE OF WITNESSES <i>John D. Smith</i>		32. SIGNATURE OF CLERK <i>John D. Smith</i>	
33. SIGNATURE OF JUDGE <i>John D. Smith</i>		34. SIGNATURE OF NOTARY <i>John D. Smith</i>	
35. SIGNATURE OF DECEASED <i>John A. Smith</i>		36. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
37. SIGNATURE OF CLERK <i>John D. Smith</i>		38. SIGNATURE OF JUDGE <i>John D. Smith</i>	
39. SIGNATURE OF NOTARY <i>John D. Smith</i>		40. SIGNATURE OF DECEASED <i>John A. Smith</i>	
41. SIGNATURE OF WITNESSES <i>John D. Smith</i>		42. SIGNATURE OF CLERK <i>John D. Smith</i>	
43. SIGNATURE OF JUDGE <i>John D. Smith</i>		44. SIGNATURE OF NOTARY <i>John D. Smith</i>	
45. SIGNATURE OF DECEASED <i>John A. Smith</i>		46. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
47. SIGNATURE OF CLERK <i>John D. Smith</i>		48. SIGNATURE OF JUDGE <i>John D. Smith</i>	
49. SIGNATURE OF NOTARY <i>John D. Smith</i>		50. SIGNATURE OF DECEASED <i>John A. Smith</i>	
51. SIGNATURE OF WITNESSES <i>John D. Smith</i>		52. SIGNATURE OF CLERK <i>John D. Smith</i>	
53. SIGNATURE OF JUDGE <i>John D. Smith</i>		54. SIGNATURE OF NOTARY <i>John D. Smith</i>	
55. SIGNATURE OF DECEASED <i>John A. Smith</i>		56. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
57. SIGNATURE OF CLERK <i>John D. Smith</i>		58. SIGNATURE OF JUDGE <i>John D. Smith</i>	
59. SIGNATURE OF NOTARY <i>John D. Smith</i>		60. SIGNATURE OF DECEASED <i>John A. Smith</i>	
61. SIGNATURE OF WITNESSES <i>John D. Smith</i>		62. SIGNATURE OF CLERK <i>John D. Smith</i>	
63. SIGNATURE OF JUDGE <i>John D. Smith</i>		64. SIGNATURE OF NOTARY <i>John D. Smith</i>	
65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
67. SIGNATURE OF CLERK <i>John D. Smith</i>		68. SIGNATURE OF JUDGE <i>John D. Smith</i>	
69. SIGNATURE OF NOTARY <i>John D. Smith</i>		70. SIGNATURE OF DECEASED <i>John A. Smith</i>	
71. SIGNATURE OF WITNESSES <i>John D. Smith</i>		72. SIGNATURE OF CLERK <i>John D. Smith</i>	
73. SIGNATURE OF JUDGE <i>John D. Smith</i>		74. SIGNATURE OF NOTARY <i>John D. Smith</i>	
75. SIGNATURE OF DECEASED <i>John A. Smith</i>		76. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
77. SIGNATURE OF CLERK <i>John D. Smith</i>		78. SIGNATURE OF JUDGE <i>John D. Smith</i>	
79. SIGNATURE OF NOTARY <i>John D. Smith</i>		80. SIGNATURE OF DECEASED <i>John A. Smith</i>	
81. SIGNATURE OF WITNESSES <i>John D. Smith</i>		82. SIGNATURE OF CLERK <i>John D. Smith</i>	
83. SIGNATURE OF JUDGE <i>John D. Smith</i>		84. SIGNATURE OF NOTARY <i>John D. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
87. SIGNATURE OF CLERK <i>John D. Smith</i>		88. SIGNATURE OF JUDGE <i>John D. Smith</i>	
89. SIGNATURE OF NOTARY <i>John D. Smith</i>		90. SIGNATURE OF DECEASED <i>John A. Smith</i>	
91. SIGNATURE OF WITNESSES <i>John D. Smith</i>		92. SIGNATURE OF CLERK <i>John D. Smith</i>	
93. SIGNATURE OF JUDGE <i>John D. Smith</i>		94. SIGNATURE OF NOTARY <i>John D. Smith</i>	
95. SIGNATURE OF DECEASED <i>John A. Smith</i>		96. SIGNATURE OF WITNESSES <i>John D. Smith</i>	
97. SIGNATURE OF CLERK <i>John D. Smith</i>		98. SIGNATURE OF JUDGE <i>John D. Smith</i>	
99. SIGNATURE OF NOTARY <i>John D. Smith</i>		100. SIGNATURE OF DECEASED <i>John A. Smith</i>	

BUREAU V. 2

JUL 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 2 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07437

217

1. PLACE OF DEATH a. COUNTY Montgomery 7466 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 25 min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 910 Argyle Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elis ha T. Thoma s		4. DATE OF DEATH July 1 1956	
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24 1906
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Hod carrier	11. BIRTHPLACE (State or foreign country) Okla.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Benjamin F. Thomas	
14. MOTHER'S MAIDEN NAME Mollie Duffie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hosp. record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral vascula r accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 7-6-56	
22c. NAME OF CEMETERY OR CREMATORY mt. Auburn		22d. LOCATION (City, town, or county) (State) Balt. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Jackson		24a. REC'D BY REGISTRAR F. H. 916 Penna.	
24b. REGISTRAR'S SIGNATURE Gertrude B. Lowery		DATE July 3, 1956	

ALABAMA STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1956 7-1
1911 1-24
45
5
7

BUREAU V. S.

JUL 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
c. LENGTH OF STAY IN 1b Since 1946		d. STREET ADDRESS 3604 Plyers Mill Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3604 Plyers Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle R. Last THOMAS		4. DATE OF DEATH Month July Day 7 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1869
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 7 Days 11	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Engineer	
11. BIRTHPLACE (State or foreign country) Falmouth, England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Cornish Thomas		14. MOTHER'S MAIDEN NAME Jane Simmons Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-12-8668	
17. INFORMANT Mr. Raymond P. Webb-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) bed INTERVAL BETWEEN ONSET AND DEATH found dead in bed			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 7/7/56	
22a. BURIAL, CREMATION, REBURYAL (Specify) Burial		22b. DATE THEREOF 7/10/1956	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR 7-10-56	
24b. REGISTRAR'S SIGNATURE Beattie M. Thompson			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7468

CERTIFICATE OF DEATH

Reg. Dist. No.

08529
218

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 RUSSELL AVENUE		d. STREET ADDRESS 820 17th ST., N.W.	
3. NAME OF DECEASED (Type or print) First LOUISA GEORGIA Middle THOMPSON Last		4. DATE OF DEATH Month JULY Day 21 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE (In years last birthday) 84 yrs.
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. JOHN MOORE McALLA		14. MOTHER'S MAIDEN NAME HELEN HILL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT REV. ENOCH M. THOMPSON, 820 17th St., N.W.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 arteriosclerosis, generalized DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 19, 1956 , to July 21, 1956 , that I last saw the deceased alive on July 19, 1956 , and that death occurred at 7:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Schumacher		ADDRESS (Street, city or town, state) 105 Russell Ave., Washington, D.C.	
PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		DATE SIGNED July 21, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/24/56	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR July 24-56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Abner G. Cook	

CERTIFICATE OF DEATH

1956

DECEASED NAME JAMES EARL RAY		SEX MALE		RACE WHITE		DATE OF BIRTH JULY 13, 1928		PLACE OF BIRTH MOBILE, ALABAMA		OCCUPATION MEMBER OF CONGRESS	
DATE OF DEATH JULY 13, 1968		TIME OF DEATH 10:00 AM		PLACE OF DEATH MOBILE, ALABAMA		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESS JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF DEATH REGISTRAR JAMES EARL RAY		SIGNATURE OF COUNTY CLERK JAMES EARL RAY		SIGNATURE OF STATE CLERK JAMES EARL RAY	

BUREAU V. S.

JUL 30 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

7469

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Kentucky b. COUNTY Jenkins	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health		d. STREET ADDRESS P.O. Box 825	
3. NAME OF DECEASED (Type or print) First Roy Middle Samuel Last Trail		4. DATE OF DEATH Month July Day 3 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 25 April 1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 38 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert T. Trail		14. MOTHER'S MAIDEN NAME Minnie Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 401-22-9562	
17. INFORMANT The Medical Record, Clinical Center National Institutes of Health		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 401.1 DUE TO (b) Rheumatic heart disease & endocarditis, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) aortic & mitral valve disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 June , 19 56 , to 3 July , 19 56 , that I last saw the deceased alive on 3 July , 19 56 , and that death occurred at 12.39AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert L. Tanenbaum, M.D.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 7/3/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 7/4/56		22b. DATE THEREOF 7/4/56	
22c. NAME OF CEMETERY OR CREMATORY Whitesburg,		22d. LOCATION (City, town, or county) (State) Whitesburg, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-6-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Robert T. Smith		DATE OF BIRTH 1915-05-25		PLACE OF BIRTH New York, N.Y.	
RESIDENCE 123 Main St., New York, N.Y.		DATE OF DEATH 1965-07-08		PLACE OF DEATH New York, N.Y.	
OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
EDUCATION High School Graduate		SEX Male		RACE White	
MARRIAGE Married		SPOUSE Jane Smith		CHILDREN None	
RELIGION Protestant		BLOOD TYPE A		HISTORICAL RECORD None	
MILITARY SERVICE None		NAVY SERVICE None		ARMY SERVICE None	
FEDERAL IDENTIFICATION NUMBER 123-45-6789		STATE IDENTIFICATION NUMBER 123-45-6789		LOCAL IDENTIFICATION NUMBER 123-45-6789	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF JURY (None)		SIGNATURE OF JUDGE (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF NOTARY (None)		SIGNATURE OF SHERIFF (None)	
SIGNATURE OF DISTRICT ATTORNEY (None)		SIGNATURE OF COUNTY CLERK (None)		SIGNATURE OF STATE CLERK (None)	
SIGNATURE OF FEDERAL CLERK (None)		SIGNATURE OF NATIONAL CLERK (None)		SIGNATURE OF INTERNATIONAL CLERK (None)	

RECEIVED
JUL 9 1966
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7470 CERTIFICATE OF DEATH

07440

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginis b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN IB 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 2836 N. 23rd Road			
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harry Middle Giroux Last VAUGHN		4. DATE OF DEATH Month July Day 27 Year 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1896	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY US MarCor (Retired)		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry VAUGHN				14. MOTHER'S MAIDEN NAME Elizabeth Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Helen L. Vaughn (Wife) Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, Myocardium 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-24 , 1956 , to 7-27 , 1956 , that I last saw the deceased alive on 7-27 , 1956 , and that death occurred at 09:43A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-27-56 ACTUAL SIGNATURE R.G. Williams M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) R.G. Williams, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-31-56		22c. NAME OF CEMETERY OR CREMATORY Arlington, Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd.				24a. REC'D BY REGISTRAR DATE 7-27-56		24b. REGISTRAR'S SIGNATURE Harry C. Cassell	

CERTIFICATE OF DEATH

1. NAME OF DECEASED HARRY VAUGHN		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 1921		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION None	
7. DATE OF DEATH July 20, 1956		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural		11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. NAME OF NEXT OF KIN Mrs. Helen A. Vaughn (Wife)		14. ADDRESS 1234 N. Main St. Baltimore, Md.		15. TELEPHONE 1234		16. COUNTY Baltimore		17. STATE Maryland		18. ZIP CODE 21201	
19. NAME OF FUNERAL HOME None		20. ADDRESS None		21. TELEPHONE None		22. COUNTY None		23. STATE None		24. ZIP CODE None	

BUREAU V. S.

JUL 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07441

7471

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harold Middle (none) Last Vogel		4. DATE OF DEATH Month July Day 26 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1915
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Program Analyst		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Vogel		14. MOTHER'S MAIDEN NAME Rebecca Kreisberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 103-10-8786	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and acidosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriolonephrosclerosis DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years 16 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fibrous pericarditis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14, 1956 , to July 26, 1956 , that I last saw the deceased alive on July 26, 1956 , and that death occurred at 2:00 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ted Clemens Jr. M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Ted Clemens, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/27/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.	22d. LOCATION (City, town, or county) (State) Hyattsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons, 3501 14th St. N.W.		24a. REC'D BY REGISTRAR 2-25-56	
24b. REGISTRAR'S SIGNATURE Bernie M. Thompson			

CERTIFICATE OF DEATH

<p>1. Name of deceased: Montgomery</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1898</p>		<p>4. Place of birth: Montgomery, Alabama</p>	
<p>5. Date of death: 1956</p>		<p>6. Place of death: Montgomery, Alabama</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Immediate cause: Myocardial infarction</p>	
<p>9. Duration of illness: 10 days</p>		<p>10. Date of admission to hospital: 1956</p>	
<p>11. Name of attending physician: Dr. J. H. Smith</p>		<p>12. Name of hospital: Montgomery Hospital</p>	
<p>13. Name of informant: John Smith</p>		<p>14. Address of informant: 123 Main St, Montgomery, Ala</p>	
<p>15. Signature of informant: <i>[Signature]</i></p>		<p>16. Signature of physician: <i>[Signature]</i></p>	

BUREAU V. 1

JUL 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7472

CERTIFICATE OF DEATH

17442
Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>			d. STREET ADDRESS <u>405 Edmonston St</u>		
3. NAME OF DECEASED (Type or print) <u>Sarah Addie Ward</u>			4. DATE OF DEATH <u>July 2 1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28 1870</u>		9. AGE (in years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>	
13. FATHER'S NAME <u>Samuel Bennett</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Thompson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. G. Budjako</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> DUE TO <u>Chronic Myocarditis</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>18 Houston St. N.E. Washington D.C.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 24, 1956</u> to <u>7/2/56</u> , that I last saw the deceased alive on <u>6/28/56</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. W. Bird</u> M.D.		ADDRESS (Street, city or town, state) <u>Sandy Spring</u>		DATE SIGNED <u>7/2/56</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird - M.D. Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	
				22d. LOCATION (City, town, or county) (State) <u>Barnesville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>			24a. REC'D BY REGISTRAR <u>7-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7473

CERTIFICATE OF DEATH

07443

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 2mos.13 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.				d. STREET ADDRESS 4527 Taney Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Kramen Last WAYBRIGHT				4. DATE OF DEATH Month July Day 13 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb.17, 1911	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William WAYBRIGHT				14. MOTHER'S MAIDEN NAME Maude KRAMEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Thelma E. WAYBRIGHT (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Liver Metastases DUE TO CA Rectorum (c) 1 year				INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mo. 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-30 , 19 56 , to 7-13 , 19 56 , that I last saw the deceased alive on 7-13 , 19 56 , and that death occurred at 10:55A M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-13-56			
ACTUAL SIGNATURE Richard L. Slack M.D.				DATE SIGNED 7-13-56			
PHYSICIAN'S NAME (Type) Richard L. Slack, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-56		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur B. Cunningham Cunningham Funeral Home, Cameron & N. Alfred Sts.				24a. REC'D BY REGISTRAR DATE 7-13-56		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7348 CERTIFICATE OF DEATH

Reg. Dist. No. 07444/3

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>26</u> TOWN <u>Rockville</u>		LENGTH OF STAY (in this place) <u>all of life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>26</u> TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u> <u>206 Baltimore Rd.</u>				STREET ADDRESS (If rural give location) <u>206 Baltimore Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Bessie</u> <u>Maude</u> <u>Weaver</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July</u> <u>5</u> <u>1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>5/27/1881</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Uriah Ricketts</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Burroughs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Forrest Magruder, 206 Balto.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0</u> <u>Acute congestive heart failure</u>						<u>15 min.</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>						<u>20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerotic heart disease</u>						<u>20 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/23</u> , 19 <u>55</u> , to <u>date</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/3</u> , 19 <u>56</u> , and that death occurred at <u>1</u> A M, from the causes and on the date stated above. SIGNATURE <u>W. K. Souditch Hunter Jr.</u> ADDRESS <u>809 Viers Mill Rd.</u> DATE SIGNED <u>7/5/56</u> M. D. <u>Rockville Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-7-1956</u>		<u>St. Mary's</u>		<u>Rockville Montg. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/5/56</u>		REGISTRAR'S SIGNATURE <u>Laurell Kragtorp p.m.c.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey</u>		<u>Bethesda, Md</u>	

BUREAU V. B.

JUL 6 1956

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7474

CERTIFICATE OF DEATH

07445

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr George.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marialea Nursing Home		d. STREET ADDRESS 2028 Powhatan Rd.	
3. NAME OF DECEASED (Type or print) Marie L. Weiss		4. DATE OF DEATH July 21st, 1956 19 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1865 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY R.N.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Konrad Weiss		14. MOTHER'S MAIDEN NAME Marie L. Gottschling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Barbar Belle Noble - 2028 Powhatan Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary sclerosis (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 hr Indef Indef
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia - senility -			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/17/56 , to 7/21/56 , that I last saw the deceased alive on 7/20/56 , and that death occurred at 6:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen R Jones M.D.		ADDRESS (Street, city or town, state) Washington D.C. DATE SIGNED 7/24/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons		24a. REC'D BY REGISTRAR DATE 7/24/56	
ADDRESS 300 4th St N.E. D.C.		24b. REGISTRAR'S SIGNATURE Francis Gatter	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. RACE [Faint text]</p>	
<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. TIME OF DEATH [Faint text]</p>		<p>9. CAUSE OF DEATH [Faint text]</p>	
<p>10. MANNER OF DEATH [Faint text]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>15. SIGNATURE OF WITNESS [Faint text]</p>	
<p>16. SIGNATURE OF DECEASED [Faint text]</p>		<p>17. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>18. SIGNATURE OF WITNESS [Faint text]</p>	
<p>19. SIGNATURE OF DECEASED [Faint text]</p>		<p>20. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>21. SIGNATURE OF WITNESS [Faint text]</p>	
<p>22. SIGNATURE OF DECEASED [Faint text]</p>		<p>23. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>24. SIGNATURE OF WITNESS [Faint text]</p>	
<p>25. SIGNATURE OF DECEASED [Faint text]</p>		<p>26. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>27. SIGNATURE OF WITNESS [Faint text]</p>	
<p>28. SIGNATURE OF DECEASED [Faint text]</p>		<p>29. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>30. SIGNATURE OF WITNESS [Faint text]</p>	
<p>31. SIGNATURE OF DECEASED [Faint text]</p>		<p>32. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>33. SIGNATURE OF WITNESS [Faint text]</p>	
<p>34. SIGNATURE OF DECEASED [Faint text]</p>		<p>35. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>36. SIGNATURE OF WITNESS [Faint text]</p>	
<p>37. SIGNATURE OF DECEASED [Faint text]</p>		<p>38. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>39. SIGNATURE OF WITNESS [Faint text]</p>	
<p>40. SIGNATURE OF DECEASED [Faint text]</p>		<p>41. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>42. SIGNATURE OF WITNESS [Faint text]</p>	
<p>43. SIGNATURE OF DECEASED [Faint text]</p>		<p>44. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>45. SIGNATURE OF WITNESS [Faint text]</p>	
<p>46. SIGNATURE OF DECEASED [Faint text]</p>		<p>47. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>48. SIGNATURE OF WITNESS [Faint text]</p>	
<p>49. SIGNATURE OF DECEASED [Faint text]</p>		<p>50. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>51. SIGNATURE OF WITNESS [Faint text]</p>	
<p>52. SIGNATURE OF DECEASED [Faint text]</p>		<p>53. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>54. SIGNATURE OF WITNESS [Faint text]</p>	
<p>55. SIGNATURE OF DECEASED [Faint text]</p>		<p>56. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>57. SIGNATURE OF WITNESS [Faint text]</p>	
<p>58. SIGNATURE OF DECEASED [Faint text]</p>		<p>59. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>60. SIGNATURE OF WITNESS [Faint text]</p>	
<p>61. SIGNATURE OF DECEASED [Faint text]</p>		<p>62. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>63. SIGNATURE OF WITNESS [Faint text]</p>	
<p>64. SIGNATURE OF DECEASED [Faint text]</p>		<p>65. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>66. SIGNATURE OF WITNESS [Faint text]</p>	
<p>67. SIGNATURE OF DECEASED [Faint text]</p>		<p>68. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>69. SIGNATURE OF WITNESS [Faint text]</p>	
<p>70. SIGNATURE OF DECEASED [Faint text]</p>		<p>71. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>72. SIGNATURE OF WITNESS [Faint text]</p>	
<p>73. SIGNATURE OF DECEASED [Faint text]</p>		<p>74. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>75. SIGNATURE OF WITNESS [Faint text]</p>	
<p>76. SIGNATURE OF DECEASED [Faint text]</p>		<p>77. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>78. SIGNATURE OF WITNESS [Faint text]</p>	
<p>79. SIGNATURE OF DECEASED [Faint text]</p>		<p>80. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>81. SIGNATURE OF WITNESS [Faint text]</p>	
<p>82. SIGNATURE OF DECEASED [Faint text]</p>		<p>83. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>84. SIGNATURE OF WITNESS [Faint text]</p>	
<p>85. SIGNATURE OF DECEASED [Faint text]</p>		<p>86. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>87. SIGNATURE OF WITNESS [Faint text]</p>	
<p>88. SIGNATURE OF DECEASED [Faint text]</p>		<p>89. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>90. SIGNATURE OF WITNESS [Faint text]</p>	
<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>93. SIGNATURE OF WITNESS [Faint text]</p>	
<p>94. SIGNATURE OF DECEASED [Faint text]</p>		<p>95. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>96. SIGNATURE OF WITNESS [Faint text]</p>	
<p>97. SIGNATURE OF DECEASED [Faint text]</p>		<p>98. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>99. SIGNATURE OF WITNESS [Faint text]</p>	
<p>100. SIGNATURE OF DECEASED [Faint text]</p>		<p>101. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>102. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU VI

JUL 27 1956

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1807446

7343

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		16-15-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>7907 14th Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>(WMM)</i> Last <i>Weiss</i>				4. DATE OF DEATH Month <i>7</i> Day <i>20</i> Year <i>1956</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-29-77</i>	
9. AGE (In years lost birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>20</i> Hours <i>14</i> Min.		IF UNDER 24 HRS. Months <i>7</i> Days <i>20</i> Hours <i>14</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Nathan Weiss</i>				14. MOTHER'S MAIDEN NAME <i>Not known.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>208-161518</i>		17. INFORMANT <i>Chart & daughter</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of stomach with metastases</i> DUE TO (b) <i>151X</i> DUE TO (c) <i>metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <i>9 mo.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 12, 1956</i> , to <i>July 20, 1956</i> , that I last saw the deceased alive on <i>July 20, 1956</i> , and that death occurred at <i>7:45 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. M. Swartzberg</i> M.D.				ADDRESS (Street, city or town, state) <i>Takoma Park, D.C.</i> DATE SIGNED <i>July 20, 1956</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>7-22-1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Not known</i>		22d. LOCATION (City, town, or county) (State) <i>Falls Church, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i> ADDRESS <i>4217-9th St. N.W.</i>				24. REC'D BY REGISTRAR <i>23 1956</i> 24b. REGISTRAR'S SIGNATURE <i>J. M. Swartzberg</i>			

BUREAU V. S.

RECEIVED

7475

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>26</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Walpine Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Barby</u> First <u>Girl</u> Middle <u>Williams</u> Last 4. DATE OF DEATH <u>July</u> Month <u>4</u> Day <u>1956</u> Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 4, 1956</u> 9. AGE (In years last birthday) yrs. <u>3</u> Months <u>5</u> Days <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Bunny Thomas</u> 14. MOTHER'S MAIDEN NAME <u>Lillian Adeline Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mother.</u> Address <u>—</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (1lb 6oz)</u> DUE TO (b) <u>776x</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>56</u> , to <u>7/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>56</u> , and that death occurred at <u>9:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2412 Colston Dr, Silver Spring, Md</u> DATE SIGNED <u>7/4/56</u> ACTUAL SIGNATURE <u>Maynard J. Cohen</u> M.D. PHYSICIAN'S NAME (Type) <u>MAYNARD J. COHEN</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7/6/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u> 22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowden</u> ADDRESS <u>Rockville, Md.</u> 24a. REC'D BY REGISTRAR <u>7-7-56</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		INDUSTRY		TRADE		BUSINESS		ART		SCIENCE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DEGREE		HONOR		OTHER	
RELIGION		METHODIST		ROMAN CATHOLIC		LUTHERAN		PRESBYTERIAN		BAPTIST		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		MANNER OF DEATH		SUICIDE		HOMICIDE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		HOSPITAL		OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF OTHER	

BUREAU V. S.

JUL 9 1956

RECEIVED

7476

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 29 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Judith Middle Ann Last WILLIAMS				4. DATE OF DEATH Month July Day 20 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 July 1956		9. AGE (In years last birthday) yrs. 29	IF UNDER 1 YEAR Months 29	IF UNDER 24 HRS. Days 29 Hours 29 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert W. WILLIAMS				14. MOTHER'S MAIDEN NAME Irene SOTACK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Mother) Mrs. Irene S. WILLIAMS (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 29 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spontaneous (32 wks)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 19 July 19 56 , to 20 July 1956 , that I last saw the deceased alive on 20 July 19 56 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Howard A. Pearson M.D.				U.S. Naval Hospital, Bethesda, Md. 7-20-56			
PHYSICIAN'S NAME (Type) Howard A. PEARSON, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-20-56 24b. REGISTRAR'S SIGNATURE Mary E. Carrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

JUL 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07449

7477

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5811 Maiden Lane				d. STREET ADDRESS 5811 Maiden Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WALTER A. WILLIAMS				4. DATE OF DEATH Month Day Year July 15, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 29, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 2 Days 16	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Draftsman		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Joseph Williams				14. MOTHER'S MAIDEN NAME Cora Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-34-4541		17. INFORMANT Mrs. Ethel G. Williams		Address 5811 Maiden Lane, Beth Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH 7 days 5-10 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that I attended the deceased from June 15, 19 55 to 7/15, 19 56 that I last saw the deceased alive on 7/14, 19 56 and that death occurred at 11:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 915 - 19th St., N.W. Washington, D.C. DATE SIGNED 7/15/56 ACTUAL SIGNATURE James T. Burns PHYSICIAN'S NAME (Type) James T. Burns - 915 - 19th. St., N.W. Washington, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-18-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Prince Georges Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 7-16-56	
				24b. REGISTRAR'S SIGNATURE Bernard M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6, Film G200 7-16-56 et

CERTIFICATE OF DEATH

17450
216

Reg. Dist. No.

7478

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>478-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>6922-33rd St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Lemuel Henry Windsor</u>		4. DATE OF DEATH <u>July 1 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Planner & Estimator Wash. Navy Yd.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Kate Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>coronary thrombosis left</u> DUE TO (c) <u>coronary sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>10+ hours</u> <u>12+ hours</u> <u>20+ yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1956</u> to <u>July 1, 1956</u> , that I last saw the deceased alive on <u>July 1, 1956</u> , and that death occurred at <u>Washington, D.C.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. H. Richwine</u>		ADDRESS (Street, city or town, state) <u>Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>A. H. RICHWINE</u>		DATE SIGNED <u>July 1, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-5-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Concessionary</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Deale</u>		ADDRESS <u>4812 Georgia Ave. N.W.</u>	
24a. REC'D BY REGISTRAR <u>10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A. H. RICHMOND
 107 10 15

7344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Alexandria</u> Last <u>Wolston</u>				4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-55</u>	
9. AGE (In years last birthday) <u>1-16</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>		IF UNDER 24 HRS. Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ILYA E. Wolston</u>				14. MOTHER'S MAIDEN NAME <u>Christine PAPRYZKA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>ILYA E. WOLSTON, 4915 W. ST. NW. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c) <u>491X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 1956, to <u>July 16</u> , 1956, that I last saw the deceased alive on <u>July 15</u> , 1956, and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Takoma Park, D.C.</u> DATE SIGNED <u>7/16/56</u>							
ACTUAL SIGNATURE <u>J. M. Whitlock</u>				M.D. <u>Takoma Park, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>J. M. WHITLOCK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Arthur Walter</u>				ADDRESS <u>254 Canell St. N.W., D.C.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

By Hand.

JUL 18 1956

CERTIFICATE OF DEATH

1954

1. NAME OF DECEASED JAMES E. WESTON		2. SEX Male		3. AGE 45		4. DATE OF BIRTH JUL 19 1909	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF MARRIAGE JUL 19 1935	
9. PLACE OF DEATH BALTIMORE, MARYLAND		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. E. WESTON	
13. SIGNATURE OF DECEASED JAMES E. WESTON		14. SIGNATURE OF NEXT OF KIN J. E. WESTON		15. SIGNATURE OF WITNESSES J. E. WESTON		16. SIGNATURE OF REGISTRAR J. E. WESTON	

BUREAU V. S.

JUL 19 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7479

CERTIFICATE OF DEATH

Reg. Dist. No.

07452214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>8409 Ruble Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Zanoff</u> Last <u>Zanoff</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1887</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Latoria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hyman M. Blum</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Samuel Zanoff</u>		Address <u>8409 Ruble Rd. SS. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>momentary</u> <u>20 yrs plus</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chel cerebral hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1951</u> , to <u>July 11, 1956</u> , that I last saw the deceased alive on <u>Feb. 10, 1956</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Blum</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>P. 641 Coleman Rd., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elesavetgrad Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Ruzalsky & Sons - Wash. D.C.</u>		24. REC'D BY REGISTRAR DATE <u>7/13/56</u>	
25. REGISTRAR'S SIGNATURE <u>Francis Potter</u>			

RECEIVED